S. Hrg. 101-480

CRISIS IN RURAL HEALTH CARE

HEARINGS

BEFORE THE

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

FEBRUARY 13, 1989—FARGO, ND
FEBRUARY 14, 1989—GRAND FORKS, ND
FEBRUARY 16, 1989—MINOT, ND

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HEALTH CARE COSTS AND THE UNINSURED

MONDAY, FEBRUARY 13, 1989

U.S. Senate,
Committee on the Budget,
Fargo, ND.

The committee met, pursuant to notice, at 10 a.m., at the Eagle Club, 3502 University Drive South, Fargo, ND, Hon. Kent Conrad presiding.

Present: Senator Conrad.

Staff present: Gorman King, Counsel and Legislative Assistant.

OPENING STATEMENT OF SENATOR CONRAD

Senator Conrad. This hearing before the Senate Budget Committee will come to order. I want to welcome all of you, say good morning, nice to have you here.

This is the only out of Washington, DC, hearing for the Senate Budget Committee on the question of health care that will be held this year. Of course there will be hearings in Washington on the important subject of health care, but these hearings will give a chance for rural America to speak on the question of what is happening to health care in our country.

We have a series of three hearings this week. The first one, of course this morning in Fargo, focusing on the question of soaring health care costs and also looking at the problem of the uninsured and the underinsured. In Grand Forks tomorrow we will have a hearing on the problems of long-term care. And on Thursday in Minot, we will have a hearing on the rural urban differential, the problem that is presenting enormous difficulties to rural hospitals across the country.

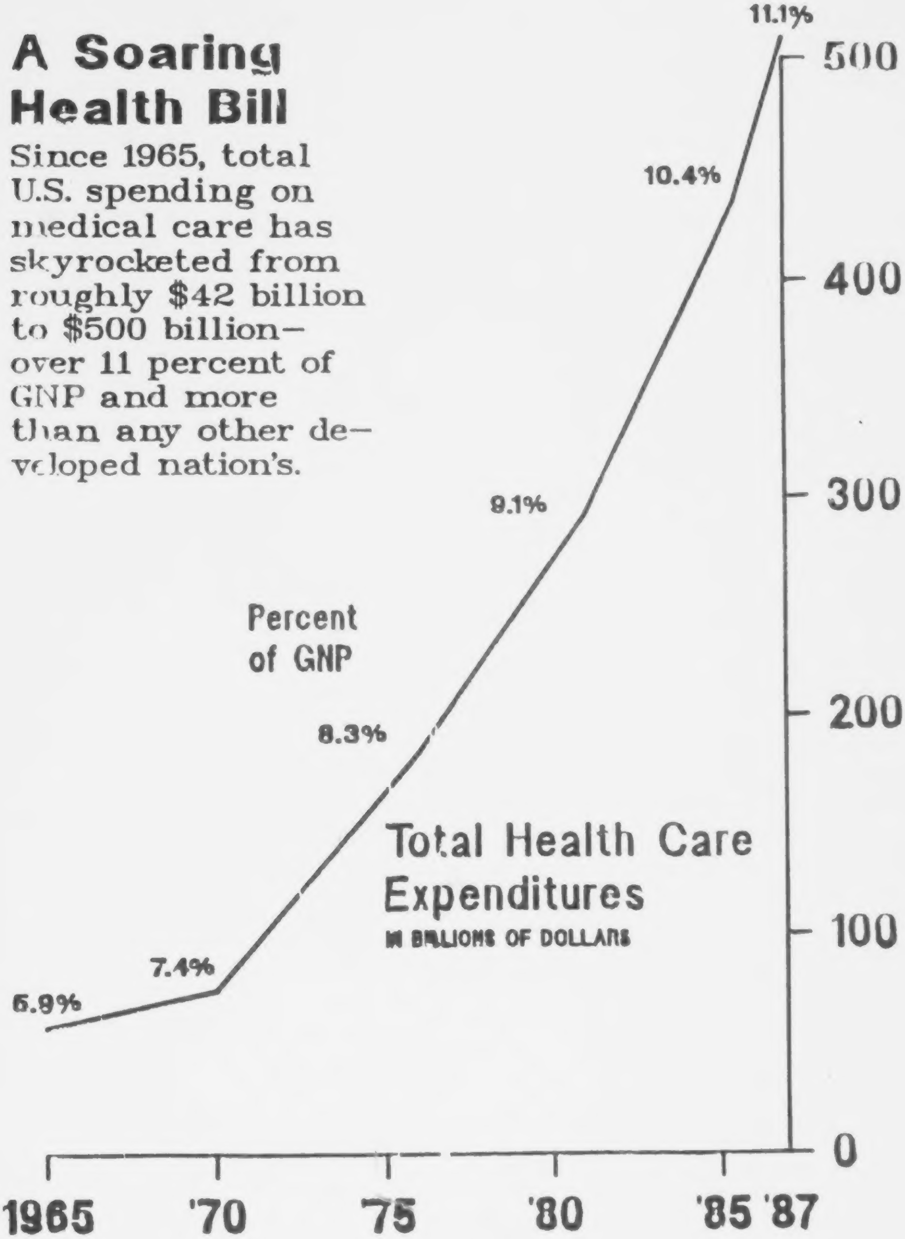
So let's start with the questions that are before us in Fargo, and the first question is one of cost, the soaring cost of health care in America. I'm going to be very brief in my remarks and then we're going to get to the panels because we have many expert witnesses here today, and I'm going to ask of each of them to be brief, to summarize their remarks.

Before we start with the panels, let's look at chart 1 which shows what's happening with health care in America. As you can see from this chart, in 1965 we were at less than $100 billion a year in total cost and that has absolutely skyrocketed. In 1988, the last year for which we have complete figures, we were over $500 billion in health care costs; and if the experts are right, we are headed for a total health care cost in 1995 that will be double what they were in 1988, and by the year 2000 they will have tripled. That is a—

obviously a projection of increase that's simply staggering to triple from 1988 to the year 2000.

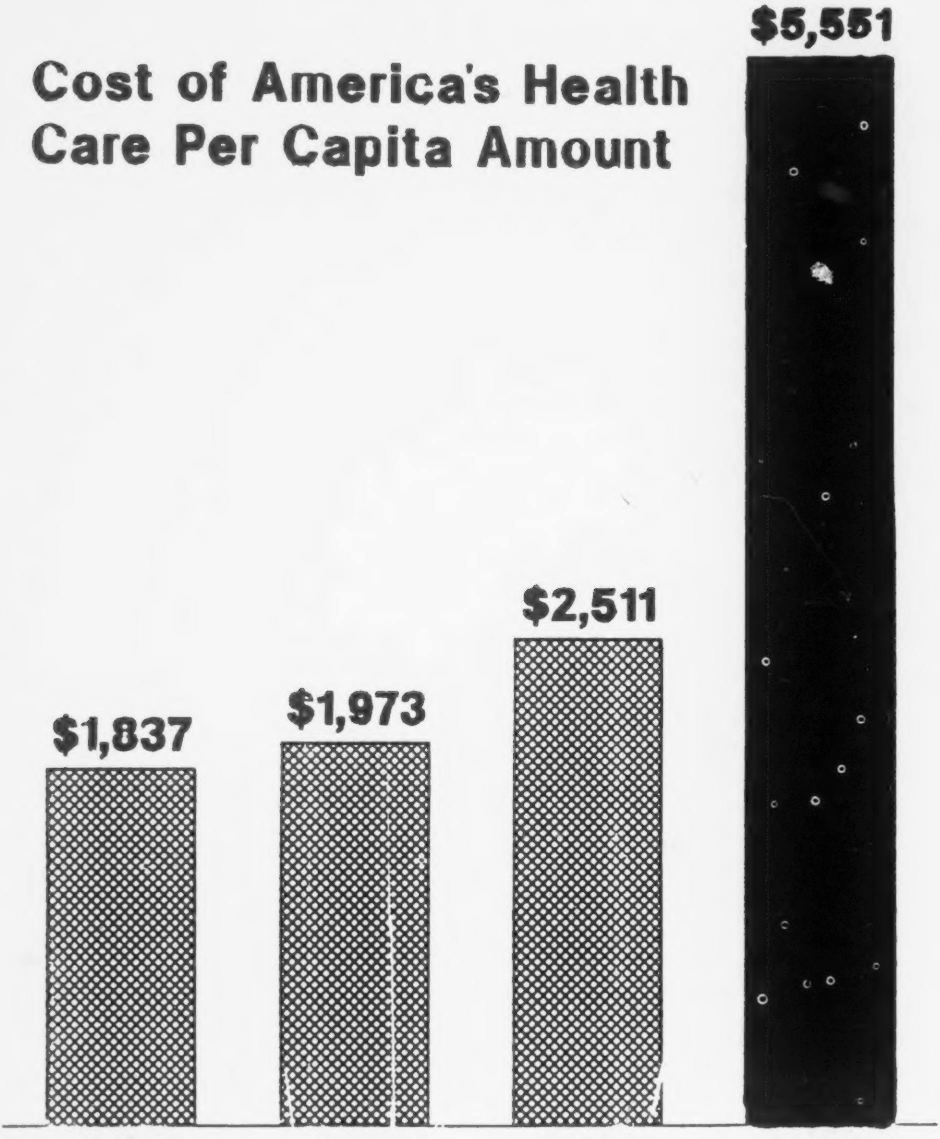
A Soaring Health Bill

Since 1965, total U.S. spending on medical care has skyrocketed from roughly $42 billion to $500 billion—over 11 percent of GNP and more than any other developed nation's.



SOURCE: HEALTH CARE FINANCING ADMINISTRATION

You can see in this next chart what it means on a per person basis. Why don't we show the next chart, Norman, that shows on per person basis, the cost of health care. You can see in 1986 for every man, woman and child in this country we were spending over $1800 a year. In 1990 that's up to $2500 a year and by the year 2000 if current trends hold, we will be spending in this country over $5500 for every man, woman and child in this country every year.



Cost of America's Health Care Per Capita Amount

SOURCE: HEALTH CARE FINANCING ADMINISTRATION

The next chart talks a little about what the reasons are for this enormous explosion in health care costs. The first reason is medical inflation. As you can see from this chart anticipated increases in prices of services covered by typical plans are responsible for almost 33 percent of the health care cost explosion.

Second major reason is cost shifting, nearly 30 percent is attributable to cost shifting, which is the shifting of costs by hospitals and doctors to the private sector from the public sector.

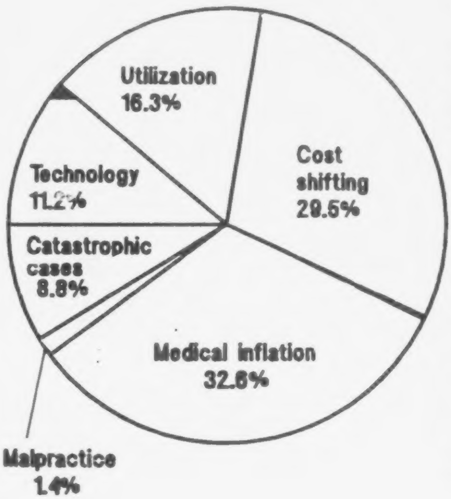
The third factor is utilization rate increases, anticipated increases in the use of outpatient and inpatient services and that accounts for about 16 percent of the increases.

Fourth technology. Additional costs from the use of the latest and best equipment and technology available which accounts for just over 11 percent of the increase.

Next is catastrophic cases, increased claims due to transplant operations, AIDS, premature infants which accounts for nearly 9 percent of the increase.

And finally, malpractice, reflects the increase in malpractice premiums and the use of defensive medicine. Obviously doctors, like all of us, don't want to lose their livelihood in a lawsuit. And so as they watch what is happening with these tremendous malpractice claims, they are protecting themselves by ordering additional tests that would otherwise not be necessary. So that gives you an overview of what we're facing in this country, what some of the underlying reasons are.

Sources of the Problem



DEFINITION OF TERMS

Medical inflation: Anticipated increases in prices of services covered by typical indemnity plan.

Cost shifting: Shifting of costs by hospitals and doctors to private sector from public sector.

Utilization: Anticipated increases in use of outpatient and inpatient services.

Technology: Additional costs from use of latest and best equipment and technology available.

Catastrophic cases: Increased claims due to transplant operations, AIDs, premature infants, etc.

Malpractice: Reflects increases in malpractice premiums and use of 'defensive' medicine.

SOURCE: Hewitt Associates

[The prepared statement of Senator Conrad follows:]

STATEMENT OF SENATOR KENT CONRAD

Senate Budget Committee Hearing
Fargo, North Dakota 2/13/89
"Crisis in Rural Health Care: Health Care Costs and the Uninsured"

Welcome and thank you for coming. Today is the first in a series of three Senate Budget Committee hearings on health care. Our focus today will be two-fold: health care costs and the uninsured. Tomorrow in Grand Forks we will examine the need for Long Term Care, and in Minot, on Thursday, we will examine Medicare and the crisis in rural hospitals.

SOARING HEALTH CARE EXPENDITURES

Health care costs are soaring out of control. While both public and private attempts have been made to control costs, few have been successful. Our nation is far ahead of any other in health care expenditures, and our cost escalation far outstrips any other nation. Americans spent $550 billion on health care in 1988, over 11 percent of the Gross National Product. Private-sector health care expenditures were about 59% of the total, while the public sector spent 41%. [Medicare and Medicaid programs accounted for most of the public sector share.] Medical care spending during the 1980s constituted the single greatest shift in spending allocation within the nation's income.

In the United States, hospital care is the dominant category of health care costs. Hospital care expenditures in 1988 rose 10% to an estimated $216.2 billion and accounted for 39% of all health care costs. Physicians' services, the second largest item, rose 12.8% to about $112.9 billion, while expenditures for nursing home care, the third largest sector, gained 9.5% to an estimated $43.8 billion. Combined expenditures for dental services, other professional services, and other health services reached an estimated $72.4 billion.

If these trends continue, costs will double by 1995 and triple by the turn of the century, hitting $1.5 trillion in the year 2000. In that year, health care will consume 15% of GNP, and this country will spend $5,551 on health care for every man, woman and child.

A new report published by the Commerce Department reports that health care expenditures are expected to increase 10.7% in 1989, putting the nation's health bill at $618.4 billion. Despite containment efforts, costs have been creeping up in the late 1980s, from a low of 9.5% in 1987 to 10.2% in 1988.

Public financing of health care is financed mostly through Medicare and Medicaid. These programs are expected to cost taxpayers $129 billion in fiscal 1989. These programs' costs have grown rapidly in the last 20 years, and substantial cost growth is expected to continue.

Private health care financing is also escalating at rapid rates. Businesses face spiraling health care premium costs. A study conducted by Nobel Lowndes, a benfits-consulting firm, indicates that premiums may rise on average of 20-30% in 1989. Although benefit managers are reluctant to pass these costs on to workers, health-industry economists say companies may have little choice.

REASONS FOR COST ESCALATION

Why are health costs skyrocketing despite aggresive cost-containment measures? The answers are manifold. First, the aging US population means Americans are using more health care services than ever before. And because of the increasing use of sophisticated technology and rising labor costs, those services are becoming more and more expensive.

At the same time, 40% of the health care offered to Americans is paid for by the government's Medicare program, and those payments haven't kept pace with the cost of providing medical care. To make money, hospitals and doctors are having to increase their prices to privately insured patients to make up for losses on government-insured patients. This cost shifting, according to a Chicago-based health care consulting firm Hewitt Associates, will account for about 30 percent of the projected rise in the cost of medical coverage during the next few years.

The inflationary trend is exacerbated by the fact that many insurance companies are giving their rates an extra boost this year to compensate for disappointing financial results last year.

Certain aspects of health care make it difficult to control costs. Due to widespread insurance coverage, patients and providers are much less responsive to prices than are consumers and payers in other sectors of the economy. Demand is also not easily susceptible to change, since, on the one hand, physicians can create their own demand and are trained to do as much as possible for their patients, and on the other hand, patients tend to develop unrealistically high expectations. To the physician, the ambiguity and complexity of certain cases, fed by the lack of adequate information on outcomes and appropriateness and fear of lawsuit, encourages extensive use of many new tests and procedures.

Patients, too, bombarded with news of exciting new treatments and wonder drugs, sometimes expect medicine to perform miracles. Some new technologies, are, indeed, somewhat miraculous. New tests uncover problems earlier than ever and some new procedures are more effective than ever. Our high technology society has a propensity to develop costly new high technologies which consumers have learned to demand. But more and more studies raise serious questions whether high technology results in better outcomes.

Reimbursement policies in place for a generation have also created an incentive to provide services that in turn increase costs. Physicians are paid for each clinical service rendered, thus creating an incentive to offer more services. New technologies constantly pouring into the market further fuel this incentive. Physicians, too, are not rewarded adequately for thinking about and implementing better care for the patient at less cost.

Malpractice suits provide another incentive for physicians to conduct many tests and procedures, particularly in high risk specialty areas such as obstetrics and gynecology and neurosurgery. Every patient is a potential litigant whose care could be questioned by a judge. The result is that physicians sometimes feel compelled to practice defensive medicine.

Other factors, too, contribute to rising health care costs. The growing number of physicians -- now 2.2 for every 1,000 and projected to reach 2.6 by the year 2000 -- is expected to continue to increase costs rather than decrease them. The nation also has too many acute hospital beds. Although the number of hospital beds has decreased in recent years -- by 1.8% in 1984-85 and another 1 percent in 1985-86 -- the drop is small and not evenly distributed across areas. The national occupancy rate for hospitals was only 68.9% in 1987. Organizations created to help hospitals and

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Senator CONRAD. Next we will hear from Monty Burke, the president of the North Dakota Farm Bureau. Again welcome, Monty. Very good of you to be here. I appreciate it and if you, too, would summarize your testimony and then we'll have time for questions. Thank you.

STATEMENT OF MONTY BURKE, PRESIDENT, NORTH DAKOTA FARM BUREAU

Mr. BURKE. Thank you very much, Senator Conrad.

Mr. Chairman, my name is Monty Burke. I live in McKenzie, North Dakota, I am a farmer and I'm also the president of the North Dakota Farm Bureau which is a voluntary organization with 24,000 members, members and families of North Dakota. And our concern for adequate rural health care and the costs of health care and all areas of health care and maintenance are very real. The policies as adopted by our House of delegates are before you Senatorian, are available for the public if they need them.

In order to address some of our concerns, the North Dakota Farm Bureau put together a special health insurance committee of selected board members and we've been studying this problem for a long time. Volumes of information have been studied and evaluated and there seems to be an abundance of statistics to prove everyone's point of view, and I would be remiss is not saying that we're very frustrated in all of the confusion that seems to come out of the situation.

I commend Commissioner Pomeroy's efforts and forthrightness in recognizing the problems and attempting to find answers, and I think that's probably elusive for him. Also the health care providers that seem to have talented people when it comes to putting together their story in justifying almost unbelievable costs for their services and it's clearly evident that the health care insurance industry has the most sophisticated computers that money can buy to justify their rate structures and trips to the sunny warm areas for board meetings.

And there are many rural people—now, let us focus our attention to rural heath care needs. As the name implies, those who fall into that category are mostly self-employed agriculturalists, as I am a farmer and rancher. There are many rural people who can afford to pay their health care costs, but a percentage of how many is very had to come by. But then there are those that simply cannot pay the cost. And an important point that I want to make is all too often health care insurance regardless of who the carrier is becomes an unbearable expense. And not to drag my personal business into it, but for my wife and I our health care insurance costs us over $3,900 and less than $4,000 a year, and that's out of our checking account all the time.

As cruel as it may be, it is often a matter of choosing between food, heat and absolute necessity or being able to pay their health care insurance premium or for health care costs. Many of these are young people with children that need health care at the very most, and we're all hopeful and we pray that these conditions can improve.

physicians be more efficient, while claiming to lower costs, may in fact introduce a new layer of cost to the health care system.

PUBLIC COST-CONTAINMENT EFFORTS

Some efforts have been made to contain costs. One of the government's major containment efforts, the Medicare's Prospective Payment System (PPS), was adopted in 1983. It had the immediate effect of slowing the increase in hospital costs; Medicare's hospital payments subsequently grew 8.2% a year, as opposed to 16.5% growth in each of the previous three years. After adjusting for inflation, PPS resulted in a 4.3% reduction in the real rate of increase in Medicare spending for inpatient hospital services. Yet during 1983-1986, Medicare's final payments for hosptial services increased faster than had been predicted, so either the quantity or scope of services may have increased.

In a second attempt to control costs, Medicare froze fees for participating physicians. Yet during this period expenditures for all physician services increased 7.2%, and Medicare expenditures for physician services increased 9.1%, suggesting there may have been an increase in procedures and office visits to compensate for lost revenues from the freeze on fees. After the freeze was lifted, physician fees under Medicare in 1986 began increasing at the same rate as all physicians fees, 11.1%, or ten times faster than the overall inflation rate in that year.

Today, cost control measures include the areas of physician payment and other outpatient services. The Congress, with advice forthcoming from the Health Care Financing Administration, the the Physician payment review Commission, is now considering whether to implement for Medicare the results of a Harvard study conducted by a team led by Dr. Hsiao. Ths study developed a "relative value scale" (RVS) for physician fees based on the costs of providing various services. If adopted for payment, it would place greater value on primary care and less on tertiary care than the current system. Dr. William Roper, Administrator at HCFA, has pointed out that while such a system might be desirable and might reduce price inequities, it would probably not significantly reduce the total cost of Medicare's payments to physicians.

Despite public and private efforts to cut costs, US health care expenditures have quadrupled and are still rising at rates much faster than the Consumer Price Index.

PRIVATE COST CONTAINMENT EFFORTS

In the private sector, cost containment has become a rallying cry in recent years. Explosive increases in employee benefits plans has forced the private sector to consider containment measures. At first the cost of increasing benefits could be passed on to the consumer, since US dominance of world markets enabled business to set world prices for their products.

But the US economic position has changed. First, a large number of early postwar employees have begun to retire, creating a large number of beneficiaries in an age group in need of substantial health care. Also, US companies are no longer unilaterally able to set the price of their products. They compete with foreign companies with a less burdensome benefit structure. US companies, challenged by international competition, are taking a close look at their costs across the board. Industry has tried to limit their costs in a number of ways:

Reducing outpatient services: For many companies, growth in outpatient services is a large obstacle to reducing costs. Employers have been able to reduce hospital expenditures by closely monitoring patient admissions and giving workers incentives to have minor surgery in outpatient services. This experiment has worked too well. Employers say the number and cost of out-patient costs have exploded. According to the Wall Street Journal, the bill for cataract surgery in some clinics is now $4,000-twice the cost in the same procedure in some hospitals. At Northwestern National Life insurance Co. in Minneapolis, spending for outpatient services among its clients has jumped almost 70% since 1983, while spending for hospital services has increased only 27%.

Health Maintenance Organizations: HMOs have long been promoted as less expensive alternatives in tradtiional fee-for-service practices. In a recent study, less than 25% of 163 surveyed companies said their HMOs helped reduce health costs. Part of the problem, benefits managers say, is that HMOs usually attract the companies young healthy workers. This drives up the cost of traditional health plans, which are left with the oldest workers. Meanwhile, the crowded HMO industry is facing a shakeout, leading some HMOs to raise prices.

Small businesses, which characterize our state, face a particularly difficult time. Providing health insurance for employees is becoming a more and more costly enterprise. Studies now indicate that many small firms have taken the step of pre-employment testing in order to determine the health of future employees.

The move, in general, to managed care -- one that was hailed with much fanfare as a cost-cutting way of delivering health care, has not been universally successful. In fact, much of the evidence indicates that managed care will not success in reducing costs.

CONCLUSION

This country is experiencing a literal explosion in health care costs, and yet no solutions are forthcoming. We are here today to investigate these rising costs, and to search for some answers. We will find today, too, that while we pay more and more, we still have a deeply troubled health care system. We will hear from those who have been left out of our health care system -- those who are slipping through the cracks.

Doctors, administrators, social service workers, state officials, insurance providers, consumers and those who represent consumers will all have the chance to speak today. Listening to their stories, perhaps we will glean further insight into the problem of health care costs and the unmet needs of many Americans.

Senator CONRAD. Next we want to turn to our first panel so that we can get a perspective on the cost question from three different parts of our community.

First, Bob Pearson, vice president of American Crystal Sugar who is representing the business community. Then we will hear from Monty Burke, the president of the North Dakota Farm Bureau who, of course, represents the farmers of our State. And finally, Earl Pomeroy, our outstanding insurance commissioner in the State of North Dakota who will give a perspective from the regulator. So without further adieu, if we can start with Mr. Bob Pearson. Bob, welcome. Thank you very much for coming.

I'm going to ask each of the witnesses today to summarize their testimony, to try to hold it to 5 minutes of summary. We will proceed with a full panel and then we'll have time for questions. And let me also indicate to you that I'm going to ask this of all of the witnesses because very frankly, we cannot get through the number of witnesses we have today unless we hold the witnesses to a 5-minute summarization. Your full written statement will appear in the record, and for those of you who aren't familiar with the ways of Washington, that's what's most critical. It's the record that we are putting together here today that will serve as a factual basis for the work of the committee in the weeks ahead. So again, Bob, welcome and proceed, please.

STATEMENT OF ROBERT J. PEARSON, VICE PRESIDENT, HUMAN RESOURCES, AMERICAN CRYSTAL SUGAR

Mr. PEARSON. Thank you, Senator Conrad, and I really appreciate being invited to participate this morning.

Health care costs for American Crystal Sugar is a very important and costly item and we're very concerned about it. Just this morning our board of directors is meeting and they're being told at this time what the costs are for post-retirement medical care for our company.[1] And in some cases that cost because of the very fact as you identified this morning, is going to be in excess of the—of their retirement benefits, the medical costs themselves will be more costly to the company than paying for retirement. That's something that our experts say that two-thirds of the Fortune 500 Companies in the United States will have post-retirement medical costs that the present, present value of those costs will exceed their corporate assets making them, at least on paper, bankrupt. That's a fact, and that is what we're here today to talk about.

And I have to say that my figures echo exactly what you said this morning, and independent studies that have been done for American Crystal, point out the same factors. One other thing that you didn't mention that I think is an important consideration is the effect of mandated benefits that have been put in place. Since 1970 there have been additional mandated benefits going from, I believe, 30 mandated benefits in 1970 to 700 by 1988. These are benefits that States and the Federal government have mandated to be included in the insurance programs that have driven the costs of insurance to a substantial degree, and as much as perhaps 3 percent of the additional cost that American Crystal is looking at was directly from mandated benefits.

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[1] See p. 179.

The issues that are before us when you talk about the factors that contribute to the problem, in my mind, the medical inflation, the cost shifting and the utilization can all be lumped into one piece, and that is what the medical community plays in driving health care costs.

We see it as a crisis that is not going to be solved by Band-Aids, things like HMO's PPO's, things that companies can do such as negotiating special rates and that sort of thing are simply Band-Aids and they won't solve the problem in the long run. It's going to take some real creative thinking and I believe some intervention from the Federal government to solve the problem.

This country has been tremendous change in the last 10 years in terms of productivity and improvements in the way we do business, and that's because of competitive pressures that have been put on from mainly outside this country. That type of competitive pressure doesn't exist in the health care industry, and I think something has to be done, some way has to be devised to create incentives for health care to be efficient.

There are models available. There are countries that do things differently than we do and that are more efficient. We need to do that because up until now it's been the case of who do we shift the costs to? Federal government can't pay their share of medicare, employees can't pay their share, many people are going uninsured because they can't afford it. Frankly, the entire country will very quickly reach a point when no one can afford the cost of medicine unless something is done, and I think it's going to take something creative and something a lot more imaginative than what we've done so far.

Thank you very much for the opportunity to be here and I'd be very interested in the rest of the comments.

Senator CONRAD. Thank you, Bob, and thank you for your excellent written testimony as well which captured many of the points that we'd earlier discussed.

[The prepared statement of Mr. Pearson follows:]

TESTIMONY

SENATE BUDGET COMMITTEE

MONDAY, FEBRUARY 13, 1989

PRESENTED BY

ROBERT J. PEARSON

VICE PRESIDENT - HUMAN RESOURCES AND PUBLIC RELATIONS

AMERICAN CRYSTAL SUGAR COMPANY

The alarming rise in health care costs is not restricted to metropolitan areas. The cost of medical care in the Red River Valley is rising at a rate that may even be higher than the national averages. Even with aggressive cost control measure initiated by some employers and insurance companies, the upward trend has been relentless.

Managed care, HMOs, PPOs, negotiated discounts and employee incentives are some of the measures in use to reduce the cost escalation. They are at best bandages trying to stop a hemorrhage.

Experts predict that 1989 will produce added cost increases in the range of 20 to 40 percent. The factors in those costs are:

Medical inflation;
Cost shifting;
Utilization;
Technology;
Catastrophic cases;
Malpractice; and
Mandated coverages.

According to Hewitt and Associates, a national health benefits consulting firm, if we assume an increase of 21.5 percent nationally for 1989, the increase breaks down as follows:

7.1 Percent (33.2 percent of the increase) is attributable to medical inflation.

6.3 Percent (29.3 percent of the increase) is attributable to cost shifting. As the number of uninsured and underinsured continues to grow, so will the shifting of costs to indemnity plans from money-losing patient categories such as Medicare, Medicaid and uncompensated care.

3.5 Percent (16.3 percent of the increase) will be due to utilization. That's because sicker inpatients are requiring longer stays and more sophisticated care, while outpatient utilization and charges are escalating.

2.4 Percent (11.2 percent of the increase) will be due to the pressure to purchase technology.

1.9 Percent (8.8 percent of the increase) will come from catastrophic cases such as organ transplants, burn cases, high-risk infant care and AIDS.

0.3 Percent (1.4 percent of the increase) will be attributable to increases in malpractice premiums and the practice of defensive medicine.

There are 37 million uninsured people in America. One fourth of those people lack basic medical insurance because the cost of state mandated health coverage keeps many employers from providing health insurance to their employees, according to a study conducted by the National Center for Policy Analysis. According to the study, the number of state mandated health coverage laws has ballooned form 30 in 1970 to almost 700 in 1988.

In response to the sharp increase in health insurance caused by mandated coverages, more large employers have established self-insured plans, which are exempt from state mandated coverage laws. However, many small employers that cannot afford to self-insure have been forced to stop offering coverage or shift the cost to the employee. Lower-paid employees who may not be able to afford the increase drop the coverage, resulting in more uninsured.

Increasing mandated coverage is part of a national trend in which the federal and state governments are attempting to expand coverage. Special interest groups representing the health care industry often pressure state legislators to pass laws requiring coverage for their members' organizations.

Several states are considering allowing insurance companies to issue low-cost, basic medical policies that would be exempt from some or all mandated benefits. While such a measure would make coverage somewhat more affordable, the other factors which drive the cost of insurance will continue to put adequate health care coverage out of reach for many people.

The three areas which make up the bulk of the increase are medical inflation, utilization and cost shifting. Together, they represent 79 percent of the expected increase in costs for 1989. Since cost shifting is a direct result of previous increases in cost, the entire 79 percent (or a 17 percent increase) is attributable to the health care delivery system itself. It is important to note that the factors most often blamed for cost increases such as malpractice, new technology and catastrophic illness make up only 21 percent of the expected increase.

Health care inflation escalates at a rate many times that of the general economy because the health care industry is not subject to the same competitive pressures as other industries. There have been dramatic improvements in efficiency and productivity throughout industry in response to competitive pressures from foreign and domestic competition. In most industries improved technology means reduced costs.

In the health care industry, there is little or no real competitive pressure. Hospitals and clinics compete based on the breadth of services offered and a perception of quality. Advertising by competing organizations focuses on services offered under one roof and subjective claims of expertise.

Competition based on services in the Red River Valley has resulted in a great deal of duplication of service and equipment. The duplication of open heart facilities, MRIs, and cancer units are examples of services that consumers pay more for today because the decision to add these facilities was based on competition for patients through services rather than the needs of the region. Having under-utilized equipment and staff also has the potential to influence the use of those assets. The fact that many medical procedures in our area are performed at rates far in excess of national norms must realistically be questioned.

The law of supply and demand simply does not apply to an industry that self regulates the utilization of its assets with little or no consumer input. For all practical purposes, once a patient is in the hands of a doctor, the treatment decisions are in the doctor's domain.

The cost shifting issue is clear. The costs generated by uninsured or underinsured patients are shifted to other payers. Many people are uninsured or underinsured largely because the cost of health care is prohibitive. Even the federal government can't afford to keep up its share of care for the elderly. Medical inflation, apart from other specific cost factors, is rising at twice the inflation rate of the general economy.

What can be done to turn this problem around?

We need to stop using bandaids to fix the problem. New, creative measures must be taken to put health care on the same competitive playing field with the rest of the country. Medical facilities should be forced to meet competitive standards that do not allow business decisions contrary to the public interest. The duplication of buildings, equipment and staff in an area like ours can only hurt the public. Federal dollars should be earmarked for research into more effective delivery of medicine. Archaic practices such as requiring a doctor to dispense drugs commonly available over the counter in many parts of the world simply drive up costs. We don't take full advantage of medical technologists, nurses and other highly trained staff.

Another area of concern is the way physicians are compensated. The recent Harvard study on physician compensation clearly indicates a fundamental flaw in the system we now use. High tech specialist are grossly over compensated for what they do when compared to primary care physicians. We recommend that the federal government mandate adoption of the Harvard study conclusions.

The bulk of the health care cost crisis is directly attributable to the inefficiency and lack of competitive pressure within the health care industry. Any long term fix must come from within the health care industry to be effective. The health care industry has done little to date to fix the problem, therefore it is appropriate for the federal government to develop a plan to encourage the health care industry to be responsible to the public.

The most mystifying and troubling part of all this to most lay people is why, why things, procedures and services cost what they do. We know it's easy and sometimes convincing to say they are life-sustaining and necessary, but this is where they or we usually go out of focus.

We understand the cost of education both in years and dollars, equipment and facilities and providing for a comfortable future are all a part of it and most of us lay people understand that, but then our vision and understanding begins to blur when we try to make sense of our recent bill due to a trip to the hospital. As our policy states, we're opposed to health insurance operated by either the State or the Federal government and we mean this very sincerely, but we must all join together to find answers to the social cancer of the unbelievable costs.

The medical profession, the doctors and all the related professions facility providers, the hospitals, clinics nursing homes, manufacturers of medical equipment, the insurance industry, the insurance care providers and I'm talking about the third party payers—Bob, in your case—the unemployed, the employed by others and the self-employed had all better get their acts together. If we cannot find answers together, and soon, I can surely see an uprising and demand for more governmental action and direction. Perhaps these hearings and more congressional hearings in every aspect of the whys and wherefores of health care and health care costs should be held.

I have an extreme amount of respect and admiration for the people in the medical profession who do provide good service at affordable prices. Certainly many, many very dedicated people can be found there and we all know that. But I have a very disturbed feeling toward those that are committing daily rip-offs. I believe they do exist. The ordinary person isn't being fooled, they're being victimized by a system that allows uncontrolled and unnecessary prices and practices in a very monopolistic business.

If there were posted prices for services and goods, one could shop in a free enterprise economy, but we know that that isn't so and it probably couldn't be in a practical application in what we're talking about. Where budgets are submitted by health care providers to justify costs, there seems to be such wide variances in reality. In some cases they're certainly on target and then in other cases there seems to be enough money left over to embark on housing and building projects that almost boggle the mind.

What I ask is the justification for allowing self-employed, unincorporated agriculturalists to deduct only 25 percent of health care insurance costs when corporations can deduct it all; and believe me, I'm not picking on corporations it's a business expense, but I can't see the justification and the discrimination against agriculturalists that are self-employed that pay all of their bill. And so it really, really seems to be an injustice, justice and I think we need to know the impact on our farm economy that that should have because you see, as I'm saying, I can only deduct $1,000 where I'm actually spending $4,000.

In conclusion, let us keep in mind that our main focus should be that health care should be available to all regardless of their station in life. I'm not talking about all the bells and whistles available—today through the miracle of modern medicine, and it's a fantastic thing. I'm talking about basic health care for all that this State and this Nation can well afford to make available for their people.

Senator, I do thank you for the opportunity, and I will be around to submit to questions. It's been a pleasure for me to be here.

Senator CONRAD. Thank you very much for that really excellent testimony.

Next we will hear from the insurance commissioner of the State of North Dakota, Earl Pomeroy, Earl.

STATEMENT OF EARL POMEROY, NORTH DAKOTA INSURANCE COMMISSIONER

Mr. POMEROY. Thank you, Senator Conrad. At the outset I want to welcome you back to North Dakota. I can tell you that life on the fifth floor in the State Capitol building hasn't been quite the same since you left the 8th, although many would suggest the quality of jokes in the lunchroom has gone up considerably. I want to also commend you for coming actually out into the field to take information on health care costs. I think even from the perspective as State regulator I have learned more going out into the communities and attempting to discuss with senior citizens in particular their concerns on health care than I have ever learned relative to information submitted to me in the Capitol building.

This morning I'm going to review the historical role of health insurance and briefly assess why the free market dynamics have broken down the delivery of health care, review circumstances which have even made a bad national situation worse in the State of North Dakota, and give you a status report on the—basically the health delivery capability in North Dakota and the affordability, consequential affordability of health insurance.

For the record, my name is Earl Pomeroy, and I'm serving as North Dakota insurance commissioner. This morning I'll also be bringing to bear the concern of my fellow insurance regulators. I serve as vice president of the National Association of Insurance Commissioners.

The historical role of our Nation's health policy has been to promote the availability of private health insurance. Employers have been allowed to deduct the cost of health insurance premiums and there has not been a resulting tax to the employees for the benefit of the premiums they received. This subsidy, which as Mr. Burke has mentioned, has not been available to self-insured or self-employed self-insured individuals. Has had a remarkable effect in making private coverage again generally to most working men and women throughout the country and in North Dakota.

While the coverage and the blanket form of the coverage has been a critical—played a critical role in having people—have health services available to them. It has separated, had the unfortunate result of separating the consumer from the cost of their care. The heart of competition as we know it is competition based on price and quality. When you separate the consumer from the costs of his or her care, you remove price as a critical part of the competition component. The insurance mechanism shifts the price for services to the insurance company from the consumer.

Raising deductible limits is a fairly recent phenomenon. We have seen deductibles raised substantially in recent years as well as including co-pay's where the individual will pay a portion of their hospitalization. This has had the effect of making the consumer somewhat more sensitive to the cost of service, but I would still contend that price as a part of the free market dynamic is not present in the delivery of health care.

We have seen the situation where the business community nationally has come forward and led the role to make—to bring about some cost competitiveness in the delivery of health care services. As the payer of the health insurance benefit for their employees, the bill has ultimately fallen upon businesses of this country. They have led the role in negotiating preferred provider discounts, brought about more stringent utilization review and engaged in other practices which have brought some competition based on price into the marketplace.

Unfortunately, the size of the employer is directly related to that employer's ability to negotiate a discount for services from the competing medical providers. In North Dakota we have predominantly small employers operating with much lower levels of negotiating ability.

I want to commend two individuals in this room, Bob Pearson and Dave Butler in the audience for their work in energizing the North Dakota's business community to become more active as relative to asserting their rights for affordable health care delivery.

Basically, unfortunately, activities of consumers to bring about more cost competitive medical services have been vigorously resistent in North Dakota. The largest employee group in the State, Public Employees Retirement System Group representing State employees went into the market and attempted to negotiate preferred provider discounts. The very intrigue and suggestion that they be allowed a discount resulted in a meeting of the board of the North Dakota Hospital Association in January of 1988, a resolution was passed whereby the Association went on record discouraging any of their members from accepting discount in payments for their health care services. This struck us as flagrant antitrust activity. We called on the Attorney General to investigate it recently. A consent decree was entered whereby they agreed to pay, the Hospital Association agreed to pay a $50,000 fine and we're enjoying it from certain practices for a ten-year period of time. I believe this demonstrates the aggressive posture taken by health care providers in trying to keep out price from competition in the marketplace.

In addition, we have seen in North Dakota market dominance of one insurance company, Blue Cross-Blue Shield. I suggest that this is again related to the fact that we don't have large employer groups and, therefore, don't have the interest of some of the national private health insurers. Making the situation worse is that North Dakota's Blue Cross-Blue Shield is one of only three in the country where the board of directors in dominated by medical providers, hospitals and doctors. Is there a conflict when the individuals—or the institutions that receive the claim payment run the insurance company that writes the claims checks? Of course there's a conflict. And I think that it has long—consumer majority on the board of directors reflecting those who pay the premiums is a long overdue development in North Dakota.

Examples of the accesses that have resulted from a fairly unquestioning liberal reimbursement mechanism are as follows: In 1976 the State of North Dakota received its first CAT scan machine. There are now 19 in operation. In 1985, the MRI machine, magnetic resonance imager, first was introduced to North Dakota, 3 million to purchase, $750,000 to maintain yearly. There are now four in the State, two in the city of Fargo, where the competing institutions rejected the proposal for one machine, located on a neutral site, subsidized with a million dollars of Federal revenue, they rejected that so they each could have their own MRI machine. There are presently six open heart units, six linear accelerators, these are used in cancer radiation treatment; and it was revealed in the press last week that St. Luke's and Dakota Clinic are both in the process of acquiring new machines for their cancer centers running in excess of $8 million per institution. Two kidney transplant centers, two neurological laser surgical units. Unquestionably, Senator, we have extraordinary high quality care available to North Dakota consumers. Unfortunately, the cost is about to break the bank in terms of our ability to maintain the range of services.

The impact on premiums have been as follows: An average Blue Cross-Blue Shield family premium costs $48 a month in 1975. In 1985, the beginning of my term as insurance commissioner the cost was $205 a month. In 1987 cost was then averaging $250 a month. Projections are for premiums to be $600 a month or above by the year 2000.

An indication of what has happened recently in medicare supplement premiums. In 1987, August we received a filing from Blue Cross-Blue Shield indicating a 15 percent adjustment was in order. We granted that adjustment. In November of the same year, 2 weeks after 13 of the board had gone to Hawaii for some type of meeting, they came back with another 15 percent rate increase. We didn't afford this rate increase till we had thoroughly scrutinized their need for it. Unfortunately by February we determined they did need that additional adjustment.

In November of last year Blue Cross-Blue Shield presented for us a 2 percent rate increase following the adoption of the catastrophic care amendments of the Medicare Program they informed me at that time that had Congress not amended the Medicare Program a 23 percent rate adjustment would have been necessary which means rates would have increased from 1987 53 percent in North Dakota for medicare supplement coverage. Now the consequences of this runaway cost inflation is that we're facing the very real potential of dramatic displacement from insurance coverage, self-employed individuals seeing very flat to marginally declining return on the profitability of their business can simply not afford to maintain their coverage. Certainly the drought impacting our farm economy has had a devastating effect on the person's ability to maintain their coverage.

We have also seen employers backing away from their traditional commitment to provide coverage to their employees. I see one of three potential outcomes, Senator, in conclusion. We have got to have a stabilization of health insurance premiums. It will either come about by a new and dramatic exercise of self-restraint from medical providers, unfortunately given some of the accesses I have recounted this morning, it doesn't appear that self-restraint is going to be evident among North Dakota medical care providers in the near future.

Shy of self-restraint we have to have very effective cost containment asserted by third-part payers, in particular Blue Cross-Blue Shield as the major health insurer in North Dakota. Again, and unfortunately, Senator, I do not feel that their cost containment activities have been pursued as diligently as they have needed to be.

Finally, and what I think would be a tragic final alternative, would be massive governmental intervention in order to make certain that the people of this State and country have access to health care. I hope we don't come to that, Senator, but I see precious little this morning that will lead me to believe one of the first alternatives is actually going to work. Thank you.

Senator CONRAD. Thank you very much, Commissioner Pomeroy. That's powerful testimony and obviously we have a problem. As the charts that we showed initially indicate, this health care cost explosion is absolutely out of control, it's a runaway; and the ramifications of that are very serious, not only for our State, but for the rest of the country as well. And when we look at potential costs of America's health care going up to $5,500 for every man, woman, and child by the year 2000, if present trends hold, Monty, that means that your premium that's running $300 is going to be running $1,000 a month for just you and your wife.

Let me ask just based on, Monty, on what's happening now, you talked to your membership frequently and I'd be interested for you to recount for the people who are here and for the hearing record, what are farmers telling you about their ability to maintain health insurance coverage?

Mr. BURKE. Senator, I want, prior to coming here, I talked to an insurance agent that's out in the field selling insurance and he said my customers are still able to afford health care insurance. It's the customers that don't come to see me anymore that I'm concerned about, and there are many that simply can't carry it anymore. That's the effect it's having.

And in a personal sense, 5 years ago one of my sons went broke farming. Now that's no disgrace if you go broke I guess for the sense of dignity. But prior to him going broke, he got to a point where he could no longer pay his health insurance costs. He just simply didn't have the money and therein lies one great tragedy because he had four children; and if it hadn't been for a mother and father that would pay the premium, he would have been totally without health care protection except that the whims and fancies of whoever would provide it when they need it.

Our members are caught up in a dilemma, as both speakers here have indicated that we're all in a dilemma of the costs being unbelievably high. Those that are self-employed can't, many can't afford to pay it any longer. Bob's people, I understand where they're coming from. It's become an expense to industry that's almost prohibitive. I can certainly appreciate the commissioner's frustration in trying to do justice to all the people that he's working with and eventually what I see happening, and I don't take any happiness in seeing it happening, is what is regarded as a very conservative organization reaching out for government help in a dilemma that we seem to have let get totally out of control. It's a sad day indeed for me to say that, but it's a fact.

Senator CONRAD. Thank you very much. I must say to you last year when we were considering in the United States Senate the catastrophic health care bill to the effect that all those are medicare eligible in our State I mailed to all of the senior citizens of our State, a description of the catastrophic care bill, what the benefits would be, what the costs would be to them, and I asked them how would you want me to vote as your representative in the United States Senate? And I got back something like 7,000 replies, which is a remarkable response rate. 85 percent said vote for it, but that wasn't what was stunning to me. It was the statements that accompanied those ballots that were scrawled in the comment space that really struck me. And I went through all of those 7,000 looking at the comments. Now, obviously not all 7,000 commented, but literally thousands of them did and the comment that was repeated over and over to me was, Senator, unless something is done, I can't believe I'm saying this, but I will favor national health insurance. And I think all of us, or virtually all of us would like to avoid that because we all know what that means. That means government making these decisions, and certainly not always wisely, and it would be far better if we were able to keep it in the private sector.

Bob, let me pursue with you a question. Can you tell me in your contacts in the business community, how would you rate as a concern of people in the business community the rising health costs? Where would this fit in terms of overall concerns that the business community has when you talk to your colleagues?

Mr. PEARSON. I think in terms of overall issues on a national basis, it is extremely high and within the human resources community that I deal in, our number one priority. I have a paper here from the National Association of Manufacturers entitled Meeting the Health Care Crisis. I'll submit this to you. On a national level human resources professionals who are—handle health care issues for corporations in manufacturing see this as one of the most critical issues that we have to deal with, clearly the largest cost issue. And I can only echo what's been said today, something has to be done because as a country we simply can't afford it.

One thing I'd like to add to that if I can, the testimony that Commissioner Pomeroy made this morning was excellent and one of the things he brought up was, the issue of the noncompetitiveness in our community. Just one example that I think can highlight what's happening, I was in Bismarck at a hearing when these magnetic resonance imaging machines were brought up, and the Federal government came in and said they'd put one of these machines at the VA. They would give us a grant, give the State a grant of a million dollars, provide the space and it would be on neutral ground. We were told at that time that around $500 would be the fee to have one of these procedures done. That was rejected by the Fargo community health care providers. They wanted to own their own and have the profit from their own machines.

Today if you go to—my figures say that if you go to St. Luke's you pay $800, and if you go to Dakota Clinic you pay $630, I believe those are the numbers. Blue Cross is willing to pay $630. I don't believe any patient is told that if you go to one place you're going to pay more than the other knowing that that's going to come out of your pocket. Blue Cross will only pay the $630 at either place. But what's more important is I don't think anyone is told that if it hadn't been for that decision made by the health care providers, that the cost would be $500. That's the key, the difference between the $500 and the $630 or $800 is in that escalation and that's what's driving costs and I believe that at some point the health care providers have to take a responsibility to this community they serve.

At one time health care was a community trust. Today it's a monopolistic business and it no longer meets the community needs and we can see it today. if you look at the numbers, it explains it all. Thank you.

Senator CONRAD. Thank you, Bob.

Let me, Earl, really put you on the spot because I visited with the health care providers and will be having them testify here today as well; and they say to me, look, we're engaged in a struggle for survival, we have got a highly competitive marketplace, we're operating at relatively low levels of occupancy, we are beset with government regulations which does not fully fund the care that we're providing to people, we have a community that wants everything for everybody and right now, we have demands that are being placed on us by society that have to be funded some way, and we might agree that the fees are extraordinarily high, but we're providing an extraordinarily high level of care for everyone in this society, and we're in competition, and what are we to do? What's the—what do you say to people who are in that position?

Mr. POMEROY. I want to begin to answer your question by acknowledging a couple of very legitimate points that providers have relative to the frustrations they have to provide care and keep it affordable. There is widespread allegations and in particular the rural rate for medicare reimbursements are not adequate and do not truly reflect costs of rural institutions. There is also legitimate points I believe that the consumers have developed tremendously high expectations for services. Certainly when it comes to the health that of my family, I don't want any cost cutting. I want the best of everything available.

On the other hand, I believe that some of the insatiable quests for higher forms of technology is provider driven. It wasn't consumers that rejected the one MRI machine alternative as Bob Pearson's just told us about. It is not the consumers that exist upon bloated advertising budgets, air ambulances and other whistles and bells that figure into elaborate marketing schemes used by the institutions to attract patients.

I believe that by and large the public would be very content to have more price competition factored into the health care delivery program. I have strenously and thus far without success urged Blue Cross-Blue Shield to reimburse according to the cost levels of the institution. If I as a patient use a cheaper institution, why should I have to pay the same out-of-pocket deductible as if I used a very high-cost institution, I believe the patients should be given rewards for chosing cost-effective alternatives. I think this might have the incidental benefit of keeping our rural health care facilities alive. Certainly there are certain diagnoses which can be treated more cost efficiently in a rural hospital without all the elaborate technologies and advertising budgets than some of the regional medical centers, but at least to date, our major health care insurance gives the consumer no incentive whatsoever for using a lower cost provider.

Without question, the providers have their legitimate frustrations. Another one that's constantly thrown at me is the fear of medical malpractice. First the cost of the premium, and premium costs are unbelievable; and then secondly, the need for defensive medicine. Admittedly, that adds to the cost equation, but as pointed out by the pie chart this morning, it is a minor role far, far below the medical inflation and costs of the elaborate and duplicated technologies. So I think that when all is said and done, most of the blame comes back to their own doorstep.

Senator CONRAD. Well, I would like to continue this discussion with this panel much longer. All of you have made valuable contributions here this morning. I very much appreciate your particpation; but given the number of witnesses we have and the ground we want to cover, we're going to need to move to our next subject area, and again my personal thanks for your coming here and making this, making this effort. Thank you.

Well, we've been talking about health care costs and we'll continue to talk today as we go through the hearing about health care costs from different perspectives. But there's another part of the problem that we want to address in the hearing this morning and that is the problem of in the presence of these enormously escalating costs, the harsh reality, this of unmet needs because we have many people in this country with no health insurance. I am told that almost 20 percent of the population of our country under the age 65 have no health insurance. We have the problem here in North Dakota as well. The available statistics indicate that 10.6 percent of the people in our State have no health insurance. 10.6 percent of the people in North Dakota have no health insurance. Many people have the image that those people without health insurance are people without jobs. They're people who have not managed to be part of the overall economy and that's simply not the case. 78 percent of North Dakota's uninsured are working people, 26 percent are working full time. Let me just repeat that. In North Dakota of the total numbers of people who are uninsured, 78 percent have a job, 26 percent are working full time.

Now, we focus on the question of those who are hospitalized. Now, if we look at those who are hospital patients, the numbers are somewhat different, but still a majority are employed. 58 percent of the hospital patients in North Dakota, according to a study that was done by the, I believe, the Hospital Association, North Dakota Hospital Association did this study in 1988, 58 percent had a job, 28 percent wes employed full time, 30 percent part time, 42 percent were unemployed. Now, this is just hospital patients. The other number I gave you, 78 percent being employed were all of those without health insurance. So this is not a problem that just relates to those who have not found a job. And one of the more startling statistics is that in North Dakota 25 percent of the families with five children under 18 are uninsured, so we have a problem that goes right to the youngest and most vulnerable among us, the children. 24 percent of those in North Dakota who are insured, this percent have no coverage for their children. Even though they have insurance, 24 percent have no coverage for their children.

Well, that's obviously a special concern and to address that, I'd ask the next panel to join us. Kay Johnson, the director of the Health Division of the Children's Defense Fund. Dr. Jack Geller, a Ph.D., the Center for Rural Health, Grand Forks. Mike Callahan, director of planning, the Lutheran Health Systems, and the former Health Care Data Administrator for the North Dakota State Department of Health. Welcome to you, panel. I very much appreciate your joining us.

And we have with us today, we're fortunate to have with us today Kay Johnson who is the director of the Health Division of the Children's Defense Fund from Washington DC. Kay Johnson is someone who is well known in this field. She has written numerous publications and articles including the Health of America's Children, The Maternal and Child Health Data Book, she's provided testimony for presidential commissions and congressional hearings including testimony before the Senate Committee on Human and Labor Resources. We are very fortunate to have with us today Kay Johnson, a recognized expert in this field, and, Kay, please proceed.

STATEMENT OF KAY JOHNSON, ACTING DIRECTOR, HEALTH DIVISION, CHILDREN'S DEFENSE FUND

Ms. JOHNSON. Thank you, Senator. The Children's Defense Fund is pleased to have this opportunity to testify before you and the citizens of North Dakota today regarding uninsuredness and its effects on the health of children. As you know, the Children's Defense Fund exists to provide a strong and effective voice for the children of America because they cannot vote, lobby or speak for themselves. For more than 15 years, our efforts to improve programs and policies for poor children have focused on the issue of access to health care.

I want to thank you, commend you Senator, for holding this hearing today to focus attention on one of the major health threats to children, the lack of adequate health insurance. The erosions in family income, health insurance and health status have led to an epidemic of uninsuredness, and it's extremely timely for a hearing such as this to be held.

In order to appreciate the scope of this epidemic of uninsuredness and the barriers to health care services that it creates, we must consider the following questions: What is the extent of health insurance coverage for families, particularly for children and pregnant women? What is the relationship between the insurance status, health care utilization and health status of children, what is its effect in other words? And what can be done to improve health care as to children?

In the interest of time I will make my comments brief and submit my fill text for the record.

First, what do we know about the health insurance status for children and pregnant women? In recent years, as you've indicated, uninsuredness has been growing and children are especially likely to be uninsured. In fact, children are one-third of those 37 million uninsured Americans. As a result of reductions in coverage under employer-based health plans and reductions in Federal, State and public insurance programs for low-income children, fewer children today have health insurance coverage.

By 1986 nearly one out of every five children in families had no health insurance, public or private. In that year more than four out of every ten children in employed poor families had no health insurance, public or private, and those children have been traditionally left outside of the scope of the Medicaid Program and they've increasingly lost family based employer dependent coverage.

Indeed, the absence of health insurance, public or private, is most clearly seen on low-income working families. Children in low-income working families are less likely to have access to employer-based family cover, and yet nonetheless are unlikely to be eligible for medicaid. Many of these children are in a group we call the near-poor. Their family incomes are above $10,000 a year, but below the $20,000 a year for a family of three.

In 1986 3 out of 10 children in near-poor families had no health insurance and in that year just over half of near-poor children had private employer-based coverage. Moreover, among that group, so we have just over half the children whose families are working who actually have some kind of dependent coverage the workplace, in only 32 percent of the cases where the cost of that health insurance covered by the employer or the union. In the other virtually two-thirds of the cases the family had to pick up part or all of the costs of that health insurance coverage, and we know for these families that really is a burden.

Of course, the best way to ensure that a child will begin life as healthy as possible is to ensure the health of a mother during pregnancy. Women of childbearing age need access to health care, particularly during pregnancy and yet inadequate health insurance coverage has acted as a barrier to this care for women. Among women of childbearing age and if we include women whose health insurance does not have a maternity benefit, over 14 million women are completely uninsured for maternity care in the United States.

And we've had recent Federal changes to ensure coverage of all poor pregnant women by 1990, and yet we have millions of near-poor woman who continue to be insured or underinsured and these women are generally young, they're married, they're in an employee family with an income just under $20,000 a year. They are the most typical of the family that's giving birth today.

The second question is what's the relationship between health insurance status and health care use and health status? In other words, what's the effect of this on the child? Studies have shown that health insurance is really the key to health care. Obviously, we've heard today what the cost of health care is. I, however, think it's also important to consider that the average cost of health care for a child is about $600 a year, and that's a lot of money to pay-out-of pocket for a family just in terms of routine preventive care and care for the cold and the flu, and the basic immunizations and other things that children need in those early years of life.

Our national survey data revealed that lowincome uninsured children have a lower likelihood of and a lower average number of visits to doctors. However, we know that poor children with medicaid coverage are more likely than uninsured poor children to have a regular source of health care, particularly children who are covered by Medicaid tend to use the services in a pattern that's very much like their privately insured more affluent counterparts. Similarly, uninsured lowincome women are less likely to receive care early in pregnancy and they're more than twice as likely to have no prenatal care.

We know that adequate access to health care is critical to maternal and child health and it can save money by preventing unnecessary illness, death and disability.

Maternity care, beginning with prenatal care and continuing through the birth of the child can have a dramatic effect on the health of the mother and the baby. Prenatal care has been shown to save $3 for every $1 that we invest in it, and yet in 1986 up to more than 10,000 babies born in North Dakota 18 percent were born to women who did not receive prenatal care in the first 3 months of pregnancy. And among non-white North Dakota women, 44 percent did not receive early care. In that year nationwide one in four babies did not receive early prenatal care and benefit from it.

Our institute of medicine which is part of our prestigious National Academy of Sciences has looked at this problem in relationship to the health of mothers and babies, and they report that "financial barriers, particularly inadequate or no insurance and limited personal funds, were the most important obstacles reported in studies of women who received insufficient care." From New York City to Oklahoma City, these studies really documented the financial barriers that keep women from receiving early and adequate prenatal care. It's often thought that women don't get to seek prenatal care because they don't know about it or they aren't educated enough to know about it. And these studies show that women know about it, they care about it, but then they try to seek care but are turned away because they can't afford and they have no means to pay for it.

We know that immunizations can prevent death and disability from now-preventable childhood illnesses. We know that immunizations can save $10 for every $1 that we invest in them, and we save billions of dollars by first round or first decade of measles activity in this country and we continue to save billions of dollars with immunizations for particularly important childhood diseases. And we know that inadequate immunization levels can lead to outbreaks of preventable disease. However, between 1980 and 1985 immunization levels for our Nation's infants and toddlers, eroded significantly. And in 1987 there were 17 cases of pertussis, that's whooping cough, were reported here in North Dakota. That doesn't sound like a lot of cases, but it was almost 10 percent of the cases nationwide. Virtually all of those cases would have been preventable if the children had been adquately immunized, and that number gives North Dakota a rate that places it among the 12 worst States in terms of pertussis. So it really is a very critical issue how we immunize their children and what their access to health care is.

The first question is what can we do to improve the health insurance status of children? Senator, I think we understand how to keep children healthy. No child, whether they need immunization, they need treatment for strep throat, they need dental care, hospitalization, or eyeglasses, should go without health care because their families cannot afford it. The Nation cannot afford that. No pregnant woman should be denied prenatal care because she does not have the money to pay for it. She should not be forced in a situation where she shows up at the emergency room door in labor, having never seen a health provider. It's not good for her health, it's not good for the health of her baby and we pay tens of thousands of dollars when that baby is born unhealthy and requires neonatal intensive care as was shown in one of your charts earlier.

The current gaps in health insurance and medical care among children are costly both in human terms and in fiscal terms, and at the same time we know that maternity can be cost effective. Our highly sophisticated can offer preventive and remedial care for almost all of the childhood health problems that we face today, and yet a series of events have left our children vulnerable to preventable childhood disease to disability and death.

Medical indigency of course not only creates a serious threat to the health of the children and a burden to their families, it also poses a threat to the health care system that cares for low-income families. Many public and private community clinics and institutions who treat the poor are under serious financial stress largely because of a large size of the medical indigent population they have to serve and also because of shortfalls in reimbursement rates that we heard discussed a little while ago.

There are really two approaches that we must take in dealing with this problem and neither is exclusive. First, we need to improve public and private insurance programs in order to generate a health care financing system that insures individuals for basic services. And in the case of children and pregnant women the cost of insurance reforms may be particularly modest in comparison to the long-term cost associated with the failure to make that assessment. Second, we need direct subsidies to public and community institutions who provide a large volume of care for the uninsured. We cannot afford to have rural health clinics and public hospitals closing leaving no place for uninsured families to go.

In recent years, Congress has taken steps to improve access to health care for pregnant women, infants and children, and these changes include those in key maternal and child health programs such as medicaid, the Maternal and Child Health Block Grant program which sends money to States to operate primarily activities in the commune health department level, Community and Migrant Health centers, Health Manpower programs and the Childhood Immunization programs.

Let me just discuss for a moment medicaid as an example of an important reform in maternal and child health. The Medicaid Program is primarily——

UNIDENTIFIED SPEAKER. Five minutes, sorry.

Senator CONRAD. No; I should have announced before I started that there's one exception, and Kay is our exception.

Ms. JOHNSON. It's the time commensurate to the amount of time it took me to get here, so I get to talk for 15 minutes.

So what we have in medicaid is a system that's really primarily responsible for financing the care for low-income children and pregnant women. In 1987 we had more than 11 million children who received services paid for by medicaid and in that year medicaid paid for about a half a million births.

Since 1984 the Congress has enacted a series of improvements in the program, and as a result by 1990, the middle of next year, pregnant women and infants with family incomes below the Federal poverty level will be covered by medicaid in all States. And several States have extended coverage to pregnant women with family incomes below 185 percent of the Federal poverty level which is roughly $18,000 a year for a family of three.

In addition, 30 States have used their option to extend coverage to some of the youngest children with family incomes below the poverty level. However, we know that more than 2 million poor children remain uncovered nationwide.

In North Dakota, families often lack the health insurance coverage they need. For many families who are self-employed or who are working in small business dependent coverage is not a common benefit nor is it affordable when purchased on an individual basis. However, medicaid coverage for poor children is quite limited. With the State's program primarily covering only children in the poor single parent families who qualify for cash assistance and clearly many of the families who need health insurance for their children, don't fall into that narrow category; that means that thousands of low-income children in North Dakota remain uninsured.

In 1987, North Dakota served approximately 15,000 children through medicaid, that was about half of all of the poor children in that State in that year. In North Dakota the statistics suggest that as many as 2,500 births occur in families with no health insurance, public or private. And the story is similar in a dozen other States. Tight State and local budgets alone cannot compensate for the deficiencies in child health financing and the Federal government's contribution to the costs of reducing medical indigency is critical.

If the Nation is to make real progress in reducing infant and childhood death and disability, then the reforms that we've undertaken since the mid-1980's must be strengthened. First of all, Congress and the States further reduce must add to uninsuredness among poor pregnant women, near-poor pregnant women and children. New Federal mandates for medicaid coverage for these groups should be phased in over the next few years. Medicaid coverage should be provided to all pregnant women and infants with family incomes below 200 percent of the Federal poverty level. And the Federal outlays for that program over the next 3 years would be about $120 million. The Medicaid Program should also be expanded to cover all poor children. The Federal share of this expansion would be approximately $200 million over the next three years and both of those proposals are pending before Congress now.

In addition, States should be given the opportunity to improve their medicaid programs in a number of ways to update them, to modernize them, to make them work not just like a welfare system, but work more like a health insurance company. And there are a series of low-cost initiatives that would make the Federal and State eligibility stations meaningful at the low-community level and for individual standards.

Second, Congress should expand access to health care through enhancement to publicly funded health programs, funding for the community, migrant health centers should be expanded and the maternity and infant services initiative in that program should be extended. The Title V Maternal and Child Health Block Grant program should be expanded to allow States to develop better comprehensive maternal and child health services so that immunizations are available in every county, for example.

Funding levels for the childhood immunization program itself must remain adequate to ensure the purchase of the necessary levels of doses of vaccine and also to provide information to families about the availability and the safety of vaccines and to generally purport our national vaccine system.

In addition, because a health manpower crisis looms on the horizon, poor and rural community health manpower programs which are designed to provide scholarship and loan assistance to health professional students and graduates who are willing to work in help manpower shortage areas, should be fully funded in fiscal 1990.

I think, Senator, the question is not whether we can afford to do all of this and whether we can afford these reforms specifically, but whether the Nation can afford not to enact them. Our recommendations have a fiscal year 1990 price tag of approximately $700 million. The first year costs alone of caring for infants born too soon and too small whose condition could have been prevented if the Nation had made sufficient progress toward its national goals, will exceed $6 billion by the year 2000. The cost of reform CDF recommends is very small compared to the cost of caring for children over a lifetime whose disabilities could have been prevented with prenatal and early childhood care. These expenditures represent a basic level of investment in the health and safety of all our children, and we don't believe that we can delay further their enactment. Thank you.

Senator CONRAD. Thank you very much, Kay. I appreciate that testimony which will be important to the deliberations of the Budget Committee. I think you make a very good point in terms of investment. The numbers are really quite persuasive in terms of $700 million and you have very easily identified savings in the area of health care for children.

[The prepared statement of Ms. Johnson follows:]

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Testimony of
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Before the Budget Committee
on
Uninsuredness and Its Effects on Child Health

February 13, 1989

Senator Conrad:

The Children's Defense Fund (CDF) is pleased to have this opportunity to testify before you today regarding uninsuredness and its effects on the health of children. The Children's Defense Fund exists to provide a strong and effective voice for the children of America who cannot vote, lobby, or speak for themselves. We pay particular attention to the needs of low income and minority children. For more than 15 years, our efforts to improve programs and policies for poor children have included extensive work on the issue of access to health care.

I want to thank you and commend you, Senator, for holding this hearing today to focus attention on one of the major threats to child and family health, lack of adequate health insurance. The erosions in family income, health insurance, and health status have led to an epidemic of uninsuredness. Thus, it is extremely timely for a hearing to be held to review this problem.

In order to appreciate the magnitude of the epidemic of uninsuredness and the barriers to health care services which exist for children and families, we must answer the following questions:

- What is the extent of health insurance coverage for families, particularly children and pregnant women?
- What is the relationship between the insurance status, health care utilization, and health status of children?
- What can be done to improve the health of children?

In the interest of time, I will make my oral comments brief today. However, I would like to submit a complete written statement for the record.

1. WHAT IS THE EXTENT OF HEALTH INSURANCE COVERAGE FOR CHILDREN AND PREGNANT WOMEN?

In recent years, the problem of uninsuredness has been growing. Children are especially likely to be uninsured as a group. As a result of reductions in coverage under employer-based health insurance plans and reductions in federal and state public insurance programs for low-income children, fewer children today have health insurance coverage.

Poor children, whose families generally lack the means to pay for health care expenses "out-of-pocket" are especially likely to be uninsured.

- Between 1980 and 1985, the proportion of children under age 18 covered by employer insurance fell by 6 percent (from 64.6 percent to 60.6 percent. Among poor children under age 18, the proportion privately covered declined by one-quarter, from 16.9 percent to 12.8 percent. [1]
- In 1986, nearly one out of every 5 children in families -- over 11 million nationwide--had no health insurance, public or private. (Table 1)
- By 1986 nearly one third of all poor children were completely uninsured. This translates into 4 million poor children nationwide. While an estimated 1.5 million children have been added to the Medicaid program since 1986, the remaining 2.5 million lack the key to access to health care--insurance.
- In 1986, more than 4 out of every 10 children in employed poor families had no health insurance public or private. These children have traditionally been left outside of the scope of the Medicaid program and, increasingly, their families lack employer based dependent coverage. (Table 2)

The absence of health insurance, public or private, is most clearly seen in low income working families. These children are less likely to have access to employer-based family coverage, and yet nonetheless are unlikely to be eligible for Medicaid. Many children in such families could be classified as "near-poor" (with family incomes between 100 and 200 percent of the federal poverty level).

- In 1986, nearly 3 out of 10 children in near-poor families had no health insurance. (Table 2A)
- In that year, just over half of near-poor children had private, employer-based health insurance coverage. Moreover, among this group, the full cost of the children's premiums was covered by the employer or union in only 32 percent of the cases.

The best way to ensure that a baby will be born healthy, is to ensure the health of the mother during pregnancy through prenatal care. Women of childbearing age need access to health care, especially during a pregnancy. Yet inadequate health insurance coverage acts as a barrier to health care for women.

- Among women of childbearing age (15-44 years), 9.5 million had no health insurance, public or private, in 1985. If women who have some health insurance but lack adequate maternity care coverage were included then over 14 million women were completely unprotected against the cost of maternity care in 1985.[2]

While recent federal changes in Medicaid ensure coverage of all poor women beginning in 1990, millions of near-poor women continue to be uninsured or underinsured. These women, young, married, in a employed family with an annual income of just under $20,000, are most typical of those who give birth today.

2. WHAT IS THE RELATIONSHIP BETWEEN INSURANCE STATUS, HEALTH CARE UTILIZATION, AND HEALTH STATUS?

Studies have shown that health insurance is a significant determinant of health care utilization. The uninsured use substantially fewer services than their insured counterparts, even when health status and the need for services is taken into account.[3] Research also has shown that even among the poorest families, health care coverage can bring health care utilization up to average levels. [4]

- National survey data reveal that low-income uninsured children have a lower likelihood of, and a significantly lower average of, visits to physicians. When adjusted for health status, uninsured children remain most likely to have no physician visits in a year. [5]
- Even among children with identified disabilities who participate in special education programs, lack of health insurance has been found to be associated with reduced access to necessary health care. [6]
- However, poor children with Medicaid coverage are far more likely than their uninsured counterparts to have a regular source of health care and to visit a physician in a year. Medicaid recipient children use services in a pattern similar to that of their affluent, privately insured counterparts. [7]
- Uninsured low income women are less likely to receive care early in pregnancy and are twice as likely to receive late or no prenatal care. [8]

Adequate access to health care is critical to maternal and child health and saves money by preventing unnecessary illness, disability, and death.

Maternity care, beginning with prenatal care in the critical first three months of pregnancy and continuing through the birth of a child, can dramatically improve maternal and infant health. An infant born to a women receiving no prenatal care is more than 3 times more likely to die in the first year of life. Prenatal care can save $3 for every $1 invested. [9] Yet each year, millions of infants are born to women who did not receive early care.

- In 1986, 18 percent of women in North Dakota did not receive prenatal care in the first three months of pregnancy. Among nonwhite women, 44 percent did not receive early care. (Table 3)
- In that year, nearly one in four babies nationwide were born to a mother who did not benefit from early care. (Table 4)

The Institute of Medicine of the National Academy of

Sciences reports that "financial barriers--particularly inadequate or nor insurance and limited personal funds--were the most important obstacles reported in 15 studies of women who received insufficient care."[10] From New York City to Oklahoma City, these studies document the financial barriers which keep women from receiving early and adequate prenatal care.

Immunizations, beginning in the first months of life, can eliminate the death and disability that can result from now-preventable, childhood diseases such as measles, mumps, pertussis (whooping cough), diphtheria, tetanus, polio, and meningitis. Childhood immunizations save $10 for every $1 invested. Yet between 1980 and 1985, immunization levels for our nation's infants and toddlers eroded significantly. [11] Inadequate immunization levels lead to outbreaks of preventable disease.

- In 1987, 17 cases of pertussis (whooping cough) were reported in North Dakota. While this number may seem small, the rate was 2-4 per 100,000, placing North Dakota among the twelve worst states in pertussis rankings. [12] (Figure 1)
- Nationwide in 1987, there were over 2,800 reported cases of pertussis, with nearly half occurring among infants. In that year, there were over 1,000 cases of measles and over 800 cases of mumps among preschool age children (younger than age 5). [13] (Figure 2)

Comprehensive primary and preventive care for children can detect and treat a wide range of health conditions before they become serious. Screening for lead poisoning, learning disabilities, vision impairments, and dental health needs can reduce the consequences of these health problems. Children who receive comprehensive primary health care have annual health costs 7 to 10 percent lower than those who do not. However, many children do not receive such preventive care.

- In 1986, as a result of inadequate access to health care, poor children were considerably more likely than affluent children to have had a routine physical in the previous year.[14]
- National surveys indicate that poor children are at least 3 times more likely than affluent children to have never had a physician visit (5.4 percent and 1.6 percent, respectively).[15]

3. WHAT CAN BE DONE TO IMPROVE CHILDREN HEALTH AND HEALTH INSURANCE STATUS?

We understand how to keep most children healthy. We know that every child needs health care. Good medical care begins before a child's birth with comprehensive prenatal care. It continues throughout childhood, with care for a child's preventive, acute, and chronic health care needs.

No child--whether the need is for immunization, treatment for a strep throat, dental care, hospitalization, medicines, or eyeglasses--should go without health care because a family cannot afford it. No pregnant woman should be denied prenatal care because she does not have enough money to pay for it.

The current gaps in insurance coverage and medical care among children are costly in both human and fiscal terms. While maternity and pediatric services have been found not only to be effective, but they have been shown to be a remarkably cost-effective type of health care investment. Our highly sophisticated medical system can offer preventive or remedial care for most child health problems. Yet a series of events have left our children vulnerable to preventable childhood disease, disability, and death.

Medical indigency not only creates an extremely serious threat to the health of low income children and families, but it also poses a substantial threat to the health care system that cares for low income families. Many public and community clinics and institutions treating the poor are under serious financial stress, chiefly because of the combined effects of the large medically indigent population they treat and shortfalls among various public and private payers for their insured patients.

Thus, there are two basic approaches to dealing with the problem. Neither is exclusive. First, we need to improve public and private health insurance programs in order to generate a health care financing system that insures individuals for basic services. In the case of children and pregnant women, the cost of insurance reforms may be particularly modest in comparison to the longterm costs associated with failure to make such reforms. Second, direct subsidies to public and community institutions providing a large volume of care for the uninsured are needed, in order to promote targeted improvements and services.

A. Recent Improvements in Maternal and Child Health Programs

In recent years, Congress has taken steps to improve access to health care for pregnant women, infants, and children. These include changes in key maternal and child health programs such as Medicaid, the Maternal and Child Health Block Grant, Community and Migrant Health Centers, and childhood immunization programs.

Medicaid: The Medicaid program is the primary health care financing program for low income children and pregnant women. In 1987, more that 11.6 million children under age 18 received services paid for by Medicaid. Medicaid paid for maternity care for approximately one-half million births that year.

Since 1984, in an effort to improve maternal and child health among low income families, Congress has enacted a series of Medicaid improvements. (Figure 3) As a result, by 1990 all pregnant women and infants with family incomes below 100 percent of the federal poverty level ($9690 per year for a family of three in 1988) will be covered by Medicaid, and several states will have extended coverage to pregnant women and infants with family incomes below 185 percent of the federal poverty level (roughly $18,000 per year for a family of three).

In addition, 30 states have used the option to extend coverage to some of the youngest children with family incomes below the poverty level. However, millions of poor children nationwide remain uncovered.

If all states extended coverage to pregnant women and infants with family incomes below 185 percent of the federal poverty level (nine already do so), then Medicaid will be available to cover health care costs for nearly one out of two births in the United States. If coverage were extended to all children with family incomes below the federal poverty level, Medicaid would become a source of health care financing for one in five American children.[16] A substantial proportion of these families currently have no source of health care coverage, public or private.

Title V Maternal and Child Health Block Grant: For over fifty years, the Title V Maternal and CHild Health programs have served our nation's mothers and children. Title V programs provide prenatal care to hundreds of thousands of low income and medically indigent pregnant women. Millions of children receive basic preventive health care and treatment for minor illnesses, as well as specialized health services for chronic illnesses and disabilities.

Since Fiscal Year 1987, a portion of any newly appropriated funds are earmarked for child health demonstration projects.

Community and Migrant Health Centers: The nearly 600 community and migrant health centers are comprehensive primary health clinics funded by the federal government and located in some of the most medically underserved communities in the United States. Health Centers serve nearly 6 million low income patients annually. In 1986, more than one-third of patients were children under age 14 and one in four was a woman of childbearing age. About 10 percent of all low income births nationally were to health center patients that year.

For Fiscal Years 1988 and 1989, Congress added a funding supplement to the health centers programs for infant mortality reduction services. (Basic funding levels are set at $415 million for community health centers and $45 million for migrant health centers.) The current $20 million funding level for this supplement is adequate to fund only a little over one-third of existing health centers, and even these clinics have received only about half of the amount that they needed to expand and strengthen their service capacity.

Childhood Immunization The federal childhood immunization program is the main source of public support for the nation's efforts to reduce preventable childhood disease. Through the program, grants are provided to allow state and local health agencies to purchase vaccines for millions of American children. The program also provides basic funding for the infrastructure of our national vaccine system (e.g., storage and preservation of vaccines in an emergency stockpile, centralized surveillance, and outbreak control activities).

For Fiscal Year 1989, Congress appropriated an additional $40 million for the vaccine program activities. However, following a decade of spiraling vaccine price inflation and eroding childhood immunization levels, additional funds are needed to bolster this critical system.

Health Manpower Programs: A health manpower crisis for poor and rural communities looms on the horizon. In 1981, Congress, at the urging of the Reagan administration, began a phase-out of the National Health Service Corps scholarship program. By 1988 only 40 scholarships were awarded, compared to over 4,300 in 1980. As fewer scholarships are awarded, the service pipeline in-turn will run dry.

The health manpower programs which were reauthorized by Congress in 1988 to provide scholarship and loan assistance to medical, nursing and health professions students and graduates will make a small dent in this problem. However, the nation now has over 1,900 primary care health manpower shortage areas, affecting nearly 13 million people.

B. **What Issues Await Further Action?**

If the nation is to make real progress in reducing infant and childhood death and disability, then the reform efforts undertaken since the mid-1980's must be expanded and strengthened. The following expenditures represent a basic level of investment in the health of America's children.

1. Congress and the states must act to further reduce uninsuredness among near-poor pregnant women and poor and near-poor children.

- New federal mandates for Medicaid coverage of these groups should be phased-in over the next few years. Medicaid coverage should be provided to all pregnant women and infants with family income below 200 percent of the federal poverty level. Federal outlays of approximately $120 million over the next three years would be needed to begin the phase-in.
- The Medicaid programs should be expanded to cover all poor children. The federal share of this expansion would be approximately $200 million over the next three years. Coverage for near-poor children should be phased-in in future years.
- In addition, states should be given the authority now to improve their Medicaid programs in a number of ways. For example, policies which allow states to guarantee annual enrollment periods for children, eliminate resource tests, and conduct aggressive outreach programs are important steps in ensuring that Medicaid-eligible children and pregnant women enroll in the program early and receive the preventive and primary health care they need. These are low cost initiatives which make federal and states eligibility expansions meaningful at the local community level.

2. Congress should expand access to care through enhancements to publicly-funded health programs.

- Funding for the Community and Migrant Health Centers should be expanded so that clinics can be developed in all medically underserved areas and maternity and infant services can be expanded and strengthened in all clinics. An additional $47 million is needed in Fiscal Year 1990 for the maternity and infant care initiative.
- The Title V Maternal and Child Health Block Grant should be expanded to permit states to better develop comprehensive maternity and child health services in underserved areas. An investment of an additional $100 million would permit nearly all states to develop statewide networks of providers.
- Funding levels for the childhood immunization program must remain adequate to ensure purchase of the necessary level of public sector vaccine, a system for providing families with information about the availability and safety of vaccines, and generally to support a national childhood vaccine

system. An additional $35 million is needed in Fiscal Year 1990 to protect all of our children against preventable childhood disease.

- Health manpower programs which designed to provide scholarship and loan assistance to medical, nursing, and health professions students and graduates working in manpower shortage areas should be fully funded in Fiscal 1990. Full funding for these programs would cost approximately $162 million.

CONCLUSION

The question is not whether the nation can afford these reforms but whether the nation can afford not to enact them. Our recommendations have a Fiscal Year 1990 price tag of approximately $700 million. The first year costs alone of caring for infants born too soon and too small whose condition could have been prevented if the nation had made sufficient progress to meet the Surgeon Generals 1990 Health Objective will exceed $6 billion by the year 2000. The cost of the reforms CDF recommends is very small compared to the cost of lifetimes of treatment and lost earnings for children whose disabilities could have been prevented. These expenditures represent such a basic level of investment in the health and safety of all of our children that their enactment cannot be further delayed.

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Table 1 Insurance Status of Children Younger than 18 in Families, by Income[1], Race, and Insurance Status, U.S., 1986

Income as a percent of poverty	All Races			White			Black		
	Less Than 100%	Less Than 200%	All	Less Than 100%	Less Than 200%	All	Less Than 100%	Less Than 200%	All
Children in Families (in thousands)	12,715	26.355	62,745	8,070	18.836	50,934	4,129	6,560	9.606
Percentage of insured children by type of coverage[2]									
Medicaid alone or with other coverage	52.3%	30.3%	13.4%	47.2%	25.2%	9.9%	61.6%	43.8%	31.4
Medicaid only	48.3%	26.8%	11.7%	42.9%	21.7%	8.4%	59.0%	40.7%	28.7
Employer coverage	11.5%	33.6%	61.4%	13.4%	37.3%	65.9%	7.9%	23.6%	39.0
VA, CHAMPUS, military[3]	2.2%	3.8%	3.9%	2.7%	4.3%	3.8%	--	1.4%	4.1
Other health insurance	6.0%	7.1%	7.6%	7.7%	8.2%	8.2%	--	2.9%	4.4
Percentage of children insured	67.6%	69.6%	81.1%	66.3%	69.6%	82.5%	69.9%	69.1%	73.6
Percentage of children uninsured	32.4%	30.4%	18.9%	33.7%	30.4%	17.5%	30.1%	30.9%	26.4

[1] Income measured as a percentage of the federal poverty level.

[2] Percentages may not equal 100 percent because some children have insurance from more than one source.

[3] The U.S. Department of Defense covers health care for members of the military and their dependents, including children, at military institutions and at civilian facilities.

SOURCE: Unpublished data from the U.S. Bureau of the Census. Calculations by Children's Defense Fund.

Table 2. Percentage of Children in Families with Employer-Based Coverage with All Premiums Paid by Employer or Union, by Income[1], Age, and Race, U.S., 1986

Income level	Total Number of Children With Employer-Based Coverage (in thousands)				Percentage of Children with All Coverage Costs Paid by Employer or Union			
	Less Than 100%	Less Than 200%	Less Than 400%	All	Less Than 100%	Less Than 200%	Less Than 400%	All
All races								
Under age 6	593	3,345	9.571	13,125	28.2%	31.0%	34.8%	37.9%
Ages 6-17	863	5,503	17,610	25,415	26.9%	31.8%	36.1%	38.4%
Total	1,456	8.848	27.181	38,540	27.3%	31.5%	35.7%	38.2%
White								
Under age 6	468	2.773	8.330	11.533	29.7%	31.9%	35.9%	38.8%
Ages 6-17	611	4,256	14,925	22,018	33.4%	35.0%	37.7%	39.7%
Total	1.079	7.029	23.255	33.551	31.8%	33.8%	37.0%	39.4%
Black								
Under age 6	106	479	990	1.177	--	25.5%	26.3%	27.8%
Ages 6-17	221	1.067	2.166	2,567	--	20.2%	26.0%	27.6%
Total	327	1.546	3.156	3.744	--	21.9%	26.1%	27.6%

[1] Income measured as a percentage of the federal poverty level.

SOURCE: Unpublished data from the U.S. Bureau of the Census. Calculations by Children's Defense Fund.

TABLE 2A. CHILDREN AGE 0-17 YEARSIN FAMILIES BY INCOME, RACE, AND INSURANCE STATUS, 1986

ALL RACES

(numbers in thousands)

		(100%	100-200	(200%	ALL
ALL CHILDREN	(number)	12,715	13,640	26,355	62,745
INSURED CHILDREN BY TYPE OF COVERAGE					
WITH MEDICAID	(number)	6,647	1,351	7,998	8,438
	(percent of total)	52.3%	9.9%	30.3%	13.4%
WITH MEDICAID ONLY	(number)	6,145	928	7,073	7,332
	(percent of total)	48.3%	6.8%	26.8%	11.7%
WITH EMPLOYER COVERAGE	(number)	1,456	7,392	8,848	38,540
	(percent of total)	11.5%	54.2%	33.6%	61.4%
WITH VA. CHAMPUS, MILITARY	(number)	274	724	998	2.424
	(percent of total)	2.2%	5.3%	3.8%	3.9%
WITH OTHER HEALTH INSURANCE	(number	760	1.118	1.878	4.794
	(percent of total)	6.0%	8.2%	7.1%	7.6%
TOTAL CHILDREN INSURED	(number)	8,600	9,731	18.331	50,882
	(percent of total)	67.6%	71.3%	69.6%	81.1%
TOTAL CHILDREN UNCOVERED	(number)	4,115	3,909	8,024	11,863
	(percent of total)	32.4%	28.7%	30.4%	18.9%

WHITE

(numbers in thousands)

		(100%	100-200	(200%	ALL
ALL CHILDREN	(number)	8,070	10,766	18,836	50,934
INSURED CHILDREN BY TYPE OF COVERAGE					
WITH MEDICAID	(number)	3,808	945	4,753	5,045
	(percent of total)	47.2%	8.8%	25.2%	9.9%
WITH MEDICAID ONLY	(number)	3,462	632	4,094	4,260
	(percent of total)	42.9%	5.9%	21.7%	8.4%
WITH EMPLOYER COVERAGE	(number)	1,079	5,950	7,029	33,551
	(percent of total)	13.4%	55.3%	37.3%	65.9%
WITH VA. CHAMPUS, MILITARY	(number)	216	589	805	1.916
	(percent of total)	2.7%	5.5%	4.3%	3.8%
WITH OTHER HEALTH INSURANCE	(number	625	922	1.547	4.187
	(percent of total)	7.7%	8.6%	8.2%	8.2%
TOTAL CHILDREN INSURED	(number)	5.350	7.762	13,112	42,030
	(percent of total)	66.3%	72.1%	69.6%	82.5%
TOTAL CHILDREN UNCOVERED	(number)	2.720	3,004	5,724	8,904
	(percent of total)	33.7%	27.9%	30.4%	17.5%

BLACK

(numbers in thousands)

		(100%	100-200	(200%	ALL
ALL CHILDREN	(number)	4,129	2,431	6,560	9,606
INSURED CHILDREN BY TYPE OF COVERAGE					
WITH MEDICAID	(number)	2,545	330	2,875	3,013
	(percent of total)	61.6%	13.6%	43.8%	31.4%
WITH MEDICAID ONLY	(number)	2,437	230	2,667	2,754
	(percent of total)	59.0%	9.5%	40.7%	28.7%
WITH EMPLOYER COVERAGE	(number)	327	1,219	1,546	3,744
	(percent of total)	7.9%	50.1%	23.6%	39.0%
WITH VA. CHAMPUS, MILITARY	(number)			94	394
	(percent of total)			1.4%	4.1%
WITH OTHER HEALTH INSURANCE	(number			189	422
	(percent of total)			2.9%	4.4%
TOTAL CHILDREN INSURED	(number)	2,887	1,643	4,530	7,067
	(percent of total)	69.9%	67.6%	69.1%	73.6%
TOTAL CHILDREN UNCOVERED	(number)	1,242	788	2,030	2,539
	(percent of total)	30.1%	32.4%	30.9%	26.4%

Table Percentage of Infants and Toddlers Who Were Fully Immunized[1], by Age and Race, U.S.[2], 1980 and 1985

Infants

		Polio	DTP[3]	Measles	Mumps	Rubella
Total	1980	80.0	84.2			
	1985	79.6	82.7	These vaccines are not recommended for children of this age.		
White	1980	80.9	84.9			
	1985	81.5	84.4			
Nonwhite	1980	73.2	79.0			
	1985	58.5	64.8			

Age one

		Polio	DTP	Measles	Mumps	Rubella
Total	1980	95.5	76.2			
	1985	95.2	78.3	These vaccines are not recommended for children of this age.		
White	1980	96.2	78.6			
	1985	96.9	80.1			
Nonwhite	1980	89.1	56.5			
	1985	82.3	64.9			

Age two

		Polio	DTP	Measles	Rubella	Mumps
Total	1980	80.7	87.0	83.0	83.2	80.2
	1985	76.7	85.8	81.7	77.3	78.9
White	1980	83.0	89.4	84.8	84.4	81.5
	1985	79.5	88.0	82.7	78.6	80.8
Nonwhite	1980	62.8	68.0	69.0	73.4	70.7
	1985	56.5	69.1	74.7	66.9	64.2

[1] Dosage levels are approximations of level needed to fully immunize a child of a given age: younger than age one, one or more doses of polio and DTP; at age one, one or more doses of polio and three or more doses of DTP; and at age two, three or more doses of polio and DTP and one dose of measles, rubella, and mumps vaccines.

[2] Data are from the U.S. Immunization Survey sample confirmed by parent consultation with an immunization record.

[3] DTP stands for a combined dose of diphtheria, tetanus, and pertussis vaccines.

SOURCE: U.S. Immunization Survey, Centers for Disease Control.

TABLE 3

NORTH DAKOTA

State Fact Sheet, 1986

	White	Nonwhite		Total
		Black	Total	
To all women	9,758	115	1,061	10,819
To all women age 19 and under	658	---	210	868
To women under age 15	---	---	---	---
(As percentage of all births)				
To women age 19 and under	6.7%	---%	19.8%	8.0%
To women under age 15	---	---	---	---.
Percentage of births that were low birthweight:				
To all women	4.7%	---%	6.5%	4.9%
To women age 19 and under	6.7	---	---	6.6
Percentage of all low birthweight births:				
To women age 19 and under	9.5%	---%	---%	10.7%
Percentage of babies born to women who: Began prenatal care in the first trimester				
All women	83.8%	80.0%	66.1%	82.1%
Women age 19 and under	62.2	---	51.7	59.6
Began prenatal care in the third trimester or not at all				
All women	2.0%	---%	8.6%	2.7%
Women age 19 and under	7.4	---	15.0	9.2
Received adequate prenatal care*				
All women	67.0%	73.7%	46.0%	65.0%
Received inadequate prenatal care*				
All women	3.9%	---%	15.4%	5.0%
Infant deaths per 1,000 live births				
Total infant deaths	8.3	---	---	8.4
Neonatal deaths	4.1	---	---	4.1
Postneonatal deaths	4.2	---	---	4.3

Note: See Part 2, Section A, for Surgeon General's Objectives.
* Does not equal 100 percent. See technical notes.
Source: National Center for Health Statistics. Calculations by Children's Defense Fund.

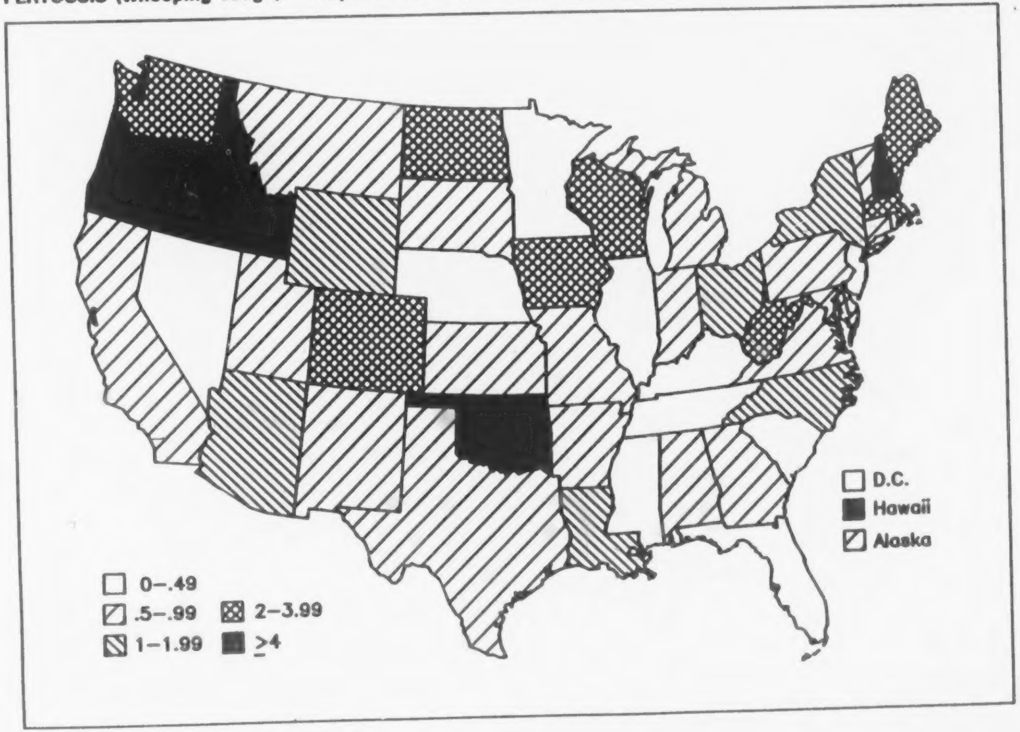
Table 4 **United States Fact Sheet, 1986**

	White	Nonwhite		Total
		Black	Total	
Births				
To all women	2,970.439	621.221	766.108	3.756.547
To women age 19 and under	315,335	141.606	156.746	472.081
To women under age 15	4.007	5,877	6.169	10,176
Teen Births As percentage of all births				
To women age 19 and under	10.6%	22.8%	19.9%	12.6%
To women under age 15	0.1%	0.9%	0.8%	0.3%
Low-Birthweight Births Percentage of births that were low birthweight:				
To all women	5.6%	12.5%	11.2%	6.8%
To women age 19 and under	7.7%	13.3%	12.7%	9.4%
Percentage of all low-birthweight births:				
To women age 19 and under	14.4%	24.1%	22.6%	17.3%
Prenatal Care Percentage of babies born to women who:				
Began prenatal care in the first trimester				
All women	79.2%	61.6%	63.7%	75.9%
Women age 19 and under	55.9%	46.8%	47.1%	53.0%
Began prenatal care in the third trimester or not at all				
All women	5.0%	10.6%	9.9%	6.0%
Women age 19 and under	11.6%	15.0%	15.0%	12.7%
Received adequate prenatal care				
All women	72.6%	50.6%	51.8%	68.4%
Received inadequate prenatal care				
All women	6.3%	15.3%	14.7%	8.0%
Infant Mortality Infant deaths per 1,000 live births				
Total infant deaths	8.9	18.0	15.7	10.4
Neonatal deaths	5.8	11.7	10.1	6.7
Postneonatal deaths	3.1	6.3	5.6	3.6

SOURCE: National Center for Health Statistics. Calculations by Children's Defense Fund.

FIGURE 1

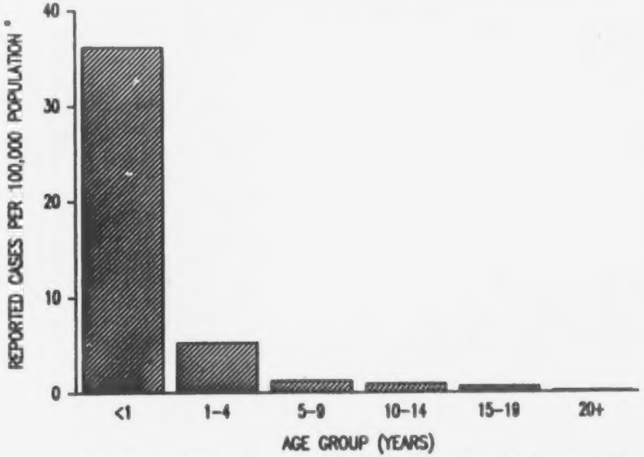
PERTUSSIS (whooping cough) – Reported cases per 100,000 population, United States, 1987


□ 0–.49
▨ .5–.99
▨ 1–1.99
▩ 2–3.99
■ ≥4
□ D.C.
■ Hawaii
▨ Alaska

SOURCE: CENTERS FOR DISEASE CONTROL

FIGURE 2

PERTUSSIS (whooping cough) — By age group, United States, 1987



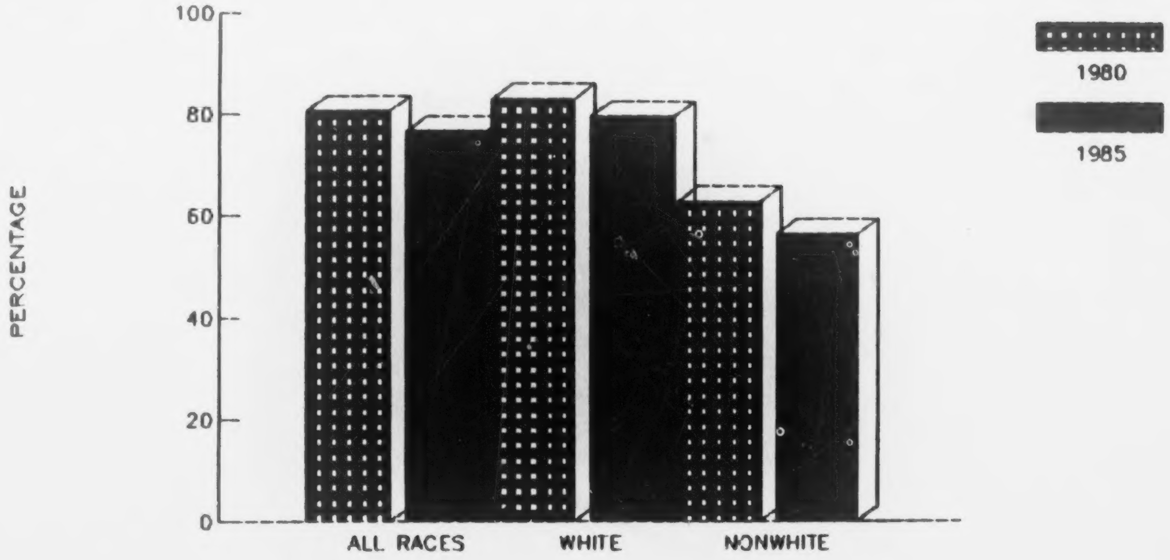
*Rates were calculated by multiplying the percentage of cases with known age group by total reported cases and dividing by the population in that age group.

SOURCE: CENTERS FOR DISEASE CONTROL

FIGURE 3

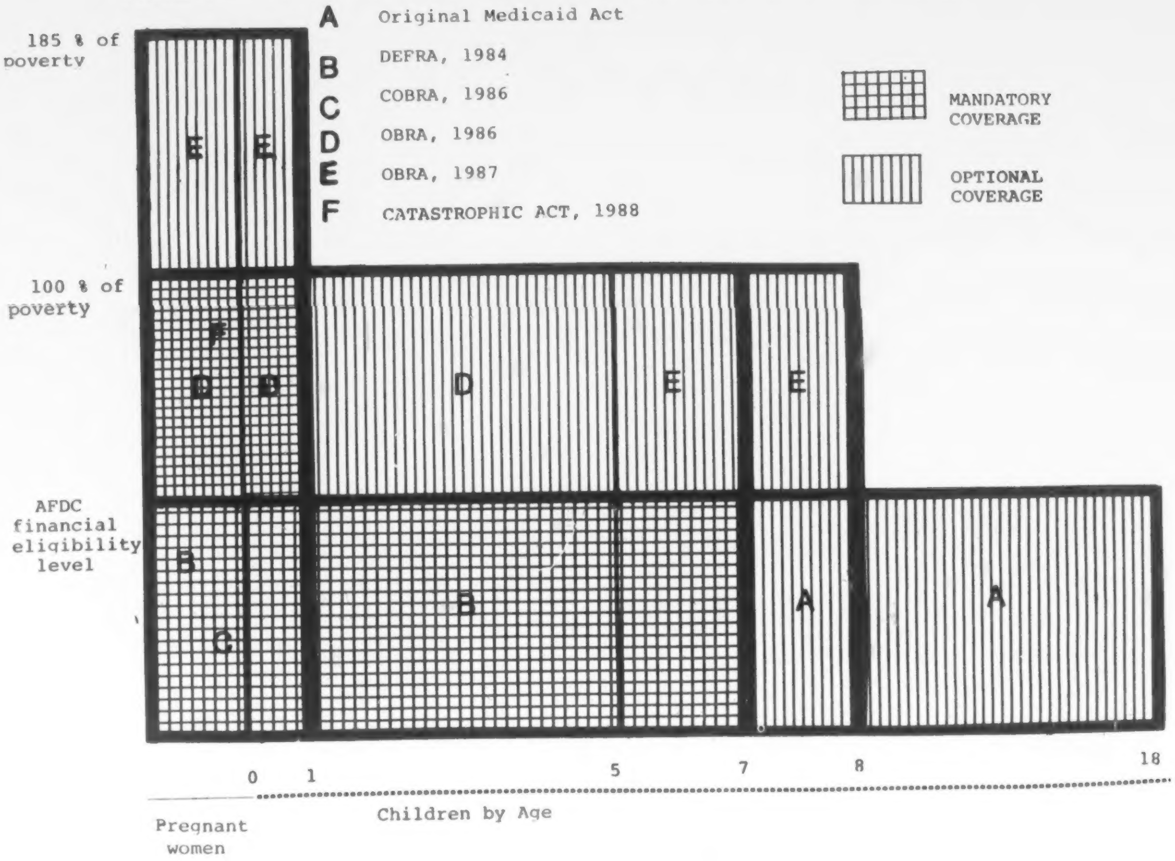
POLIO IMMUNIZATION AMONG TWO-YEAR-OLDS.

BY RACE, U.S., 1980 AND 1985



SOURCE: CHILDREN'S DEFENSE FUND

FIGURE 4 MEDICAID COVERAGE OF PREGNANT WOMEN AND CHILDREN



MATERNAL AND CHILD HEALTH IN NORTH DAKOTA
KEY FINDINGS

The health of North Dakota's children is poor and among some populations, actually getting worse.

Infant Mortality

Infant mortality is considered an indication of how well a society addresses the needs of its most vulnerable citizens.

- In 1986 North Dakota's infant mortality rate overall was 8.4 deaths for every 1,000 live births, a slight improvement over the previous year. With this low rate, the state ranked first in the nation on overall infant mortality.

- Postneonatal mortality (deaths to from 28 days to one year) continues to be a problem for infants in North Dakota. The high 1986 postneonatal mortality rate of 4.3 placed it among the worst in the nation (39th out of 49 states). It is the only state with a postneonatal rate higher than the mortality rate in the first month of life.

Low Birthweight

Low birthweight (less than 5.5 pounds) is the single largest cause of infant death and can lead to permanent disability among infants who survive.

- Among all infants in North Dakota 4.9 percent were born at low birthweight in 1986. North Dakota had the nation's second lowest overall percentage of low-birthweight babies in 1986.

- However, disparities exist in low birthweight rates among white and nonwhite infants in North Dakota. In 1986, 4.7 percent of white infants were born at low birthweight, compared to 6.5 percent of nonwhite infants.

Prenatal Care

High quality prenatal care which begins early and continues throughout pregnancy has been shown to reduce the incidence of low-birthweight births.

- In 1986, 82.1 percent of North Dakota infants were born to mothers who received prenatal care that began in the first three months of pregnancy ("early" care). Among nonwhite infants, only 66.1 percent were born to mothers who received early care, ranking the state 23rd in the nation.

- The state was 38th of 50 jurisdictions in the percentage of infants born to mothers who received adequate prenatal care. Only 6 out of 10 infants were born to mothers whose care could be called adequate in terms timing of the initial visit and the number of visits received.

- Among white infants, only 62.2 percent were born to a woman whose prenatal care could be classified as adequate. The state ranked 44th out of 50 jurisdictions--this means that only 6 states had a worse record.
- Only 51.7 percent of all nonwhite infants were born to mothers who received adequate care, and the state was 39th of 50 jurisdictions in the percentage of nonwhite infants born to mothers who received adequate prenatal care.

Key Maternal and Child Health Programs

Several programs have been shown to be efficient and cost-effective in improving the health of mothers and children. However, funding for these programs is inadequate to meet all need.

- In 1987, only 55.5 percent of children and women in North Dakota who were eligible for the Special Supplemental Food Program for Women, Infants, and Children (WIC) were actually served. However, an additional 1,000 women and children were served with state-appropriated WIC funds.
- The state's AFDC benefit level for a family of three was only $371 a month (or 45.9 percent of the federal poverty level).

January 1989
Source: National Center for Health Statistics and Children's Defense Fund.

Senator CONRAD. Let me proceed quickly to our next witness and then we'll get back to questions for the panel. And again we have a very ambitious list of witnesses today. I frankly do not believe that we will conclude testimony by 12:30, but it's important for the work of the Budget Committee that we have a full range of views expressed today, and again I want to express my thanks for the members of this panel to tell you that your full written statement will be included in the record. Replacing Jack Geller from the Center for Rural Health is Richard Ludtke, am I pronouncing that correctly, Dick?

Mr. LUDTKE. Ludtke.

Senator CONRAD. Ludtke. Perhaps you will summarize your testimony for us, and thank you for being here.

STATEMENT OF RICHARD L. LUDTKE, PROFESSOR OF SOCIOLOGY AND RESEARCH ASSOCIATE, CENTER FOR RURAL HEALTH

Mr. LUDTKE. Thank you, Senator Conrad. I'll see if I can be brief with my testimony. I have several tables on it which will be difficult to describe in detail anyway.

The remarks that I have to make at this hearing stem from the North Dakota rural life poll that Dr. Geller and I worked very closely together on. In the 1988 rural life poll we surveyed statewide the rural residence of rural North Dakota, and one of the questions that was asked in the rural life poll reflected financial adjustments that people had undertaken because of the downturn in the economy.

The question that I want to focus on this morning is the reduction of health insurance as it responds to the downturn in the economy. In 1988, 19½ percent of the respondents indicated that they had made reductions in their health insurance coverage as it responds to economic concerns. 10.6 percent of those were in the category of major adjustments. I believe they were categorized as minor and major adjustments. I believe the minor adjustments would be the increase in the deductibles and major adjustments would involve cancellation of policies.

There's a direct link between the reduction in insurance coverage and the postponement of health care. We also had a question that directly addressed whether people had postponed treatment as a financial adjustment, and there's a direct link between those that had canceled or limited their insurance coverage and those that had postponed treatment for health care needs. 63 percent of those that made major adjustments in health insurance also made major adjustments in postponing health care attention.

There are a number of factors that appear to be related to this. We can kind of profile to a certain extent the persons that are making the adjustments. There's little relationship overall on the basis of sex, but we do find that women make larger adjustments or more major adjustments than men do in terms of total adjustments, they make approximately the same number. In terms of marital status, the high-risk group would appear to be those that are classified as separated or divorced. 38.4 percent of that category indicated making an adjustment. Then the next category are the married. The least likely to have to make an adjustment are those that are classified as single and never married.

Education relates and one would expect education to relate to that kind of pattern of adjustments, the greater the education the less the adjustment that is likely. There's one exception, that's continual and that's a category that we had in the surveys that was entitled having some college which seems to indicate people that are still in the process of getting their education, there was an upturn in adjustments. In fact, that was the category that had the largest rate of adjustments after high school graduation. And that would include people that are in school who utilized insurance adjustment as the mechanism for saving money.

In terms of income levels, again as income levels go up, the need for adjustments are reduced. It's interesting, however, to note that with the income levels that approximately one-fourth of the respondents with incomes ranging between $900 and $20,000 made adjustments on their insurance according to the results of the North Dakota rural life poll.

We also examined the employment factor, and just as one of the previous testimonies had indicated, the self-employed is a category that results in significantly higher levels of adjustment. The people that are self-employed would include the small town businessmen who are—probably have less access to group insurance, more direct access to control over their insurance and can use that as the mechanism for making financial adjustments.

There's a relationship with AIDS that adds a pattern that I found rather striking because with our data it's suggestive the group that makes the largest adjustment, the group making the largest amount of adjustments in their health insurance saved financial resources ranged 45 to 64, and they're—above 26 percent of that age cohort reported making adjustments in their insurance and 14 percent, just over 14 percent are making major adjustments. That was clearly the largest group. That was a bit of a surprise to us because we had expected that the younger population would be making greater adjustments.

So the findings give a bit of a profile, but I think the findings from the rural life poll also suggest that the pattern of reducing coverage as the mechanism of financial adjustment is very widespread. It's not just among the poor, but it's among the working middle, and that attention to this problem would have to include attention to the working middle group as well. Thank you.

Senator CONRAD. Thank you very much.

[The prepared statement of Mr. Ludtke follows:]

TESTIMONY: REDUCTIONS IN HEALTH INSURANCE AMONG NORTH DAKOTA SMALL TOWN RESIDENTS

Richard L. Ludtke
Professor of Sociology & Research Associate
Center for Rural Health
University of North Dakota, Grand Forks

The following remarks are based on data taken from the small town residents portion of the 1988 North Dakota Rural Life Poll. The Rural Life Poll is an annual poll conducted by the University of North Dakota Social Science Research Institute for purposes of monitoring the changing conditions of life in rural North Dakota. In January and February of 1988 questionnaires were sent to 2000 residents of North Dakota small communities. This portion of the poll had a response rate of 43% Among the items included in the 1988 poll for small town residents was a set of items asking people whether they had, in the past 12 months, made financial or lifestyle adjustments because of current problems in the economy. A substantial proportion reported adjustments in insurance for both health care and life insurance. A total of 19.5% indicated some amount of reduction in health insurance, with 10.6% reporting major adjustments.

Table 1

Adjustments Through Reductions in Health Insurance

None	80.5%
Minor Adjustment	8.9%
Major Adjustment	10.6%

Conversations with rural providers suggests that people have dropped coverage or have increased their deductible in order to contain costs. This in turn produces a barrier to using physicians and discourages early contact as a method of limiting the severity of illness through early treatment. Evidence for the influence of reducing insurance are presented in our data (table 2). It is clear that those having made more substantial adjustments in their insurance have also made more substantial financial adjustments by postponing health care. 63% of those who made major adjustments through reducing health care coverage had also made major adjustments by postponing care. This compares with 18% of those who reported no adjustments in coverage.

Table 2

Postponement of Health Care and Reduction in Health Insurance

Postponement of Care as an Adjustment	Reduction in Health Insurance		
	None	Minor	Major
None	76.9%	37.7%	18.1%
Minor	16.2%	49.2%	18.1%
Major	6.9%	13.1%	63.9%

FACTORS RELATING TO REDUCING HEALTH INSURANCE

We also examined the relationship between several background factors and reducing health coverage. The variables that appear to relate were sex, marital status, education, income, employment status, and age.

SEX

Sex appears to relate to the magnitude of the adjustment made rather than to whether an adjustment is made or not. Males reported a lower proportion of major adjustments than did females, with 9.2% reporting major adjustments as compared to 13.3%. Women, on the other hand had a smaller proportion reporting minor adjustments.

Table 3

Sex and Reduction of Health Insurance

	Male	Female
None	80.0%	81.1%
Minor	10.9%	5.6%
Major	9.2%	13.3%

MARITAL STATUS

Marital status also relates to reducing health coverage as a financial adjustment. Those most "at risk" to reducing insurance were in the separated and divorced category, while those least likely to reduce insurance were the single, never married. The total proportion of the separated and divorced who made some adjustment was 38.4%. This is nearly double the proportion for the next group in rank order - the married who reported 19.4% using reductions in health insurance as a financial adjustment.

Table 4

Marital Status and Reduction of Health Insurance

	Married	Never Married	Widowed	Separated/ Divorced
None	80.7%	92.9%	85.3%	61.5%
Minor	9.7%	2.4%	5.9%	9.6%
Major	9.7%	4.8%	8.8%	28.8%

EDUCATION

As education increases, the proportion making financial adjustments by reducing their health insurance decreases. Clearly, those lacking a high school education are disadvantaged and those graduating from college or post graduate degrees are the most advantaged. Those with "some college" make more adjustments than either high school graduates or those with 2 year degrees or more. This may reflect a "current student" population, but again suggests that health insurance is one area in which financial adjustments can be made when pressures exists. This category also had the highest proportion, 15.7% making major adjustments.

Table 5

Education and Reduction of Health Insurance

	Under 8 yrs	8 to 11 yrs	High Sch Grad.	Some College	2yr Deg.	College Grad. +
None	55.6%	77.3%	79.0%	73.6%	92.9%	92.5%
Minor	33.3%	11.8%	8.7%	10.6%	1.8%	4.0%
Major	11.1%	10.9%	12.3%	15.7%	5.4%	3.5%

INCOME

The pattern for income is similar to that of education in that the greatest volume of reduction in coverage occurs among the lower income groups. In the lowest income category nearly 25% of the respondents had undertaken major adjustments. It is also striking that a large proportion of the moderate income categories are making adjustments in their health insurance coverage as a means of adjusting to economic constraints. Approximately 1/4 of the respondents with incomes ranging between 9,000 and 20,000 had used reducing medical insurance coverage as a tool for financial management during the past 12 months.

Table 6

Income and Reduction of Health Insurance

	Under 9,000	9,000-15,999	16,000-19,999	20,000-24,999	25,000-34,999	35,000-49,999	50,000 Over
None	69.8%	75.0%	75.6%	81.4%	82.4%	93.6%	87.5%
Minor	5.5%	8.1%	17.9%	8.2%	11.0%	3.6%	10.0%
Major	24.7%	16.9%	6.4%	10.3%	6.6%	2.7%	2.5%

EMPLOYMENT

The self employed appear to be subject to slightly more and slightly more severe reductions in coverage according to the Rural Life Poll data. They are probably less likely to be covered by group plans and have a greater measure of control over their coverage. The retired are least likely to have made adjustments in their coverage, but even among the retired nearly 15% reported having made some adjustment during the past 12 months.

Table 7

Employment and Reduction of Health Insurance

	Self Employed	Employed	Retired
None	78.8%	81.7%	85.1%
Minor	9.1%	9.0%	8.2%
Major	12.1%	9.3%	6.7%

AGE

An examination of the reduction of health insurance coverage by age groups finds the highest rates for both major and minor reductions occurring among people in the category 45 to 64 years of age. Twenty-six percent of this age group had made some financial adjustment through reducing health insurance coverage.

Table 8

Age and Reduction of Health Insurance

	Under 25	25 to 44	45 to 64	65 & over
None	83.3%	82.5%	74.0%	84.9%
Minor	8.3%	7.4%	11.7%	7.8%
Major	8.3%	10.0%	14.3%	7.3%

FAMILY SIZE

The number of dependents listed by respondents did not relate to reducing health insurance. Evidently the presence of children neither bufferred the temptation to use health insurance as a means of saving money nor did the presence of larger numbers of children yield pressure sufficient to produce more efforts to save by reducing coverage.

These findings suggest that reductions in insurance are substantial in our financially troubled rural communities. The reductions of coverage will lead to postponement of care and this in turn is likely to produce increases in severity of illnesses. These findings also suggest that the problem is not isolated with the poor or the young. The absence or limitations of health insurance present a barrier to access to professional care that endangers the health of increasing numbers of our rural residents.

Thank you for this opportunity to share these observations with you.

Next we will hear from Mike Callahan, the director of planning for Lutheran Health Systems. Thank you, Mike, for being here. We appreciate that very much and if you'd proceed with your testimony.

Mr. CALLAHAN. Thank you, Senator. In my——

Senator CONRAD. Maybe if I can just interrupt before you—I'm—when we're finished with this panel, their testimony, I'm going to open it up to the audience for you to ask questions of this panel; and if no one has questions, I have some questions, and then we'll close it off and go to the next panel. So if you hear something that you want to pursue with one of the witnesses, I'm going to give people in the audience a chance to ask questions as well.

Mike, proceed.

STATEMENT OF MIKE CALLAHAN, DIRECTOR OF PLANNING, LUTHERAN HEALTH SYSTEM

Mr. CALLAHAN. Thank you, Senator.

In my previous position with the State Health Department, I was the health data administrator. And in—just to reinforce some of the things the other panelists have said, in 1988 we collected health insurance claims data from Blue Cross—Blue Shield, medicare and medicaid, the other large insurance companies in the State; and one of the things we found in that was that those large insurers only account for about 46 percent of the live births in the State. And we compared that to the complied records data base.

My feeling was at that time that if we had gotten all the insurance claims, we probably would have picked up about half again as much, meaning that about 23 percent of the live births occurring in the State probably occurred in families that did not have health insurance to cover the event.

According to the Health Department's survey, 16 percent, just to reinforce the fact that the problem is worse in rural areas, according to Health Department surveys, 16 percent of those who listed their occupations as farmers and ranchers had no health insurance coverage at all. We know that insurance coverage in rural areas, is heavily dependent on fluctuations in farm economy and this is reflected in the recent national survey in which 40 percent of rural residents expressed a great concern for their family's ability to pay for health care as compared to only 30 percent for urban residents. In a broad sense inadequate health insurance coverage is indicative of——

Senator CONRAD. Mike, if you just stop there. That's a pretty stunning number. 40 percent of rural residents. This is nationwide?

Mr. CALLAHAN. Nationwide, expressed a great concern.

Senator CONRAD. About their ability to pay for health care for their family?

Mr. CALLAHAN. Yes, sir.

Senator CONRAD. And 30 percent in urban areas, and both those numbers are stunning. Go ahead.

Mr. CALLAHAN. I would suggest that while cost problem is, as Commissioner Pomeroy pointed out, is largely a manifestation of the rapid growth of highly specialized services in community centers, the access problem is being disproportionally felt in rural areas. In North Dakota for example, 80 percent of the hospital revenues go to the ten largest institutions, ten largest hospitals. The 42 small rural hospitals operating in this State receive about 20 percent of the totat hospital revenues, and this disparity is growing. Revenues and costs are increasing much faster in urban than in rural hospitals. Because the rural hospitals have not been part of that expansion, charges for given DRG in rural hospitals area is 25 to 50 percent lower in the smaller hospitals. But despite the lower charges, the lack of insurance is more of a problem for these facilities, in part because of ill burden and in part because they continue to pursue a community mission of providing care for the underinsured, that is probably less the case in some of the more urban areas. Thank you.

Senator CONRAD. Thank you very much.

[The prepared statement of Mr. Callahan follows:]

TESTIMONY TO SENATE BUDGET HEARING
February 13, 1989, Fargo, North Dakota

Mr. Chairman, members of the committee, my name is Mike Callahan. I am presently Director of Planning for LHS Management Company. We provide management services to 13 rural hospitals in 10 western states. Up until last month I was the Health Care Data Administrator for the North Dakota State Department of Health, where I was involved in making information on health care costs and charges available to the public. So I am going to give you my thoughts on health care costs and health insurance coverage with both of these perspectives in mind.

You probably now know that it is very difficult to determine the exact size of the uninsured population. In 1983, using data from the Health Insurance Association of America, I estimated that about 18% of the North Dakota population did not have comprehensive health insurance; that is, hospital and physician coverage. I suspect that that figure has increased substantially in the last five years.

The North Dakota Health Department's 1988 survey of insurance status indicated that overall, 10.6% of the North Dakota population had no health insurance coverage at all. If we exclude the Medicare population, all of whom have coverage, the percentage of uninsureds is approximately 13% of the population or about 75,000 people in North Dakota with no health insurance coverage. An additional 10% of the population probably has inadequate indemnity or otherwise limited health insurance coverage that does not provide enough protection in case of serious illness. Very roughly, I would estimate that as much 23% of North Dakota's Non-Medicare population has either nonexistent or inadequate health insurance coverage.

We do know that insurance coverage varies with age. For example, 98% to 99% of the over 65 population is covered by Medicare. In 1988, the Health Department collected health insurance claims data from Medicare, Medicaid and the ten largest commercial health insurers doing business in the State for 1987. This data accounted for about 70% of the total discharges in the State. However, when we compared the number of births in that data base, the total resident live births in the State's vital records data, we found that these large insurers covered only about 46% of the total births.

I had estimated at that time that we could have accounted for less than half of the missing health insurance claims if we had collected data from all insurers doing business in the State. That would leave approximately 23% of the live births in the North Dakota occurring in families without adequate health insurance to cover the event, who are not covered by Medicaid.

Health insurance coverage also varies with occupation. According to the Health Department's survey, 16% of those who listed their occupation as farmers and ranchers had no health insurance at all. We know that insurance coverage in rural areas is heavily dependent on the fluctuation in the farm economy. This is reflected in a recent national survey in which 40% of rural residents expressed a "great concern" for their family's ability to pay for health care, compared to only 30% of urban residents.

In a broader sense, inadequate health insurance is indicative of a growing conflict between the cost of health care and the need for reasonable access to it. I would suggest to you that while the cost problem is largely a manifestation of the rapid growth in highly specialized services in urban centers, the access problem is being disproportionately felt in rural areas. In North Dakota 80% of the hospital revenues go to ten large institutions. The 42 rural hospitals in this State receive only about 20% of the total revenues. And this disparity is growing. Revenues and costs are rising much faster in urban than in rural hospitals.

Because they have not been part of this expansion, hospital charges for a given DRG average 25% to 50% lower in rural hospitals. Despite their lower charges, the lack of insurance is more of a problem for these facilities for several reasons. Rural hospitals, in part due to the Hill Burton program, are more likely to provide care on a charity basis; and people are more likely to expect it. Small hospitals are often still reluctant to pursue the more aggressive collection practices such as the collection agencies that urban facilities now use.

Over 90% of the rural hospitals that LHS manages are publicly owned. Write-offs for bad debt and charity care in public hospitals doubled between 1980 and 1985. ("Medically Indigent Patients Bump Out Public Hospital's Private Paying Patients" by J. Green, Modern Health Care, May 8, 1987, p. 76)

The North Dakota Hospital Association's 1988 survey of hospital care for the uninsured indicated that 80% of the bad debt written-off was for patients who had no health insurance.

We can divide the issues in health care delivery today into two categories, those relating to cost and those relating to access. Private (Non-Medicare) hospital costs are increasing at about 16% a year. Health insurance premiums inevitably must increase to pay these costs. As a result our access problems are getting worse. For many individuals and small businesses, health insurance is no longer affordable. Rural hospitals have more to do with access than they do with costs. They have contributed relatively very little to cost increases but they do provide more than their share of uncompensated care. I would ask you to be aware of this as you consider solutions to the problem of assuring adequate insurance coverage.

Thank you.

Senator **Conrad**. Now, anybody in the audience have a question for members of this panel? Yes, sir, if you'd identify yourself so that we have your name for the record. Remember that we're functioning now under official Senate rules, and that requires that anybody who testifies or asks a question, give their name and the city that they're from or the areas that they're from and, of course, we don't want to interrupt anybody. We give everybody a chance to be heard. Yes, sir.

Mr. **Regal**. I'm William Regal. On this cost as far as the individual is concerned with this catastrophic health care bill—now, just a statement I want to make. This ever escalating surtax, not Federal taxes——

Senator **Conrad**. Sir, remember now, we're in a hearing in which before us right now is questions for this panel. That we—if you have a statement or a question on catastrophic, that isn't the subject that's before us at the moment and we will deal with that as soon as we're done with the panels. If you could——

Mr. **Regal**. Can I ask this question then?

Senator **Conrad**. Certainly, if you ask a question that's relevant to their testimony.

Mr. **Regal**. As far as the catastrophic care, health care bill, whether it's fair or not as how the costs are being assessed?

Senator **Conrad**. Well, that's really not what's being testified here to, sir. Catastrophic health care bill, we'll be glad to deal with that later on in this session. But what they're testifying to is the lack of availability of health care or the cost part of it. But we'd have to wait on that question. It doesn't fit right here. Thank you very much.

Somebody have a question they want to pose to this panel?

Mr. **Strege**. My name is Strege. I'm from Wahpeton, and my question is to Ms. Johnson. She talks about these poor people who—these poor pregnant women and the help they need and so forth, and she's never mentioned what she might do in her discussion with these people about planned parenthood. We know that we can't take care of all the kids that they want to have. What about planned parenthood or the option of sterilization or maybe as a last resort abortion? Does the government or do those people do any of that sort of thing? We just can't keep on letting them breed like cats and expect the government to take care of them. What are you doing in those cases?

Ms. **Johnson**. I would put on the record the fact that the Children's Defense Funds has no institutional position on abortion. I would extend my remarks to say to you by way of explanation for what the medicaid program actually offers to these families. The coverage is for maternity care in its fullest scope, that is prenatal care beginning from the date of medical verification of a pregnancy extending through the labor and delivery period for a child and extending 60 days after the birth of the child for visits related to recovery for the woman and family planning if she seeks it would be covered under this woman's medicaid extension that goes beyond birth. Those would be decisions that would be made between a woman and her health care provider, but if that decision were made, medicaid would pay for those services. So we have in these changes brought that opportunity to these individuals and given them the opportunity to have that coverage.

Mr. STREGE. No discussion about planned parenthood during this time?

Ms. JOHNSON. Yes; they would have 60 days after the birth of the child to discuss planned parenthood, family planning with their health care provider, and if they chose to use some kind of contraception or if they chose sterilization, perhaps it would be paid for under the medicaid system during that 60 day period. They have that coverage.

Senator CONRAD. Maybe I could just pursue at this point? This is a Budget Committee hearing and we're very interested in the budget ramifications, and Kay, if you could tell us what the impact of the budget that's been presented by the new President would have on the issues before us?

Ms. JOHNSON. Senator, as you know, health care is only one of several pressing needs among children that the Children's Defense Fund is concerned about, and we feel that the children's crisis is as urgent as the savings and loan industry's and that children's development is as critical to America's destiny as the space program and we feel that children need a place in every administration's budget as it does in the congressional budget during each session. We also feel that children need a warmer budget climate from both the President and the Congress after 8 fairly chilly years that we have experienced for children's health care and other kinds of funding. We really applaud the President's modest first steps, but we're very concerned about what his proposals actually mean for children and families. For example, the President recommends that medicaid eligibility be extended to cover pregnant women and infants and immunizations for young children, with families who have incomes up to 130 percent of the Federal poverty level. However, the President has failed to include new funds for this initiative and proposes to reduce certain medicaid expenditures to cover the cost of any expansion. So there's no——

Senator CONRAD. So who would foot the bill? Who would pay, the States?

Ms. JOHNSON. The States would be losing a portion of some matching rates that they're now receiving, exactly.

Senator CONRAD. Well, that would have serious implications for North Dakota obviously with—the State of North Dakota, I'm advised by the health experts here, is in no position to pick up additional requirements that would be sent by the Federal government. This State, as you perhaps know as everybody in this audience well knows, has been very hard hit by declining commodity values in oil and agriculture. We're probably the most devasted State in the Nation by drought this State legislature's struggling with very difficult choices and being told that they are to provide additional funding to keep the promise of the President it will be extraordinarily difficult for this State to handle it.

Well, let me, let me call on one more. Yes, ma'am.

Ms. LORE. I would just——

Senator CONRAD. If you'd identify yourself for the record, please.

Ms. LORE. Okay. My name is Edith Lore. I'm director of manage care of Dakota Hospital in Fargo. I would like to build a little on what Ms. Johnson presented earlier. As the shift in investment in care for poor, low-income pregnant women and the savings in terms of costs for children born early, premature because they have had inadequate health care, that represents a significant amount of dollars that providers are investing in the health of the community that's uncompensated, and that uncompensated care is money that hospitals are not recovering and, therefore, it is affecting the overall increase of care for every person no matter what age they are. So it has a very signficant impact on all of us.

Senator CONRAD. Could you just tell us for those that aren't familiar with the technicalities why is it uncompensated?

Ms. LORE. Most of those children who have come from poor families who have long-term health care needs because they're born prematurely, fall under the Medicaid system. And in the State of North Dakota the Medicaid system for providers of hospital care are receiving approximately 49 cents on the dollar for every dollar they invest on services. That means for every dollar we spend, we are only paid 49 cents that becomes very significant when we have babies in our institution for a year.

Senator CONRAD. Could you give us any ballpark estimate on what the dollar amount of that differential would be, the difference between the dollar of costs that your institution experiences versus the 49 cents of compensation?

Ms. LORE. For babies alone, I'm sorry, I don't have those figures with me, but it is significant.

Senator CONRAD. Thank you very much. We'll take one more from the audience. Yes, sir.

Mr. TAYLOR. My name is James Taylor. I'm from Whitefish, Montana.

UNIDENTIFIED SPEAKER. Can't hear you.

Mr. TAYLOR. My name is James Taylor. I'm from Whitefish, Montana and I've been doing a lot of working on the homeless stuff, and I wanted to ask Ms. Johnson what are they doing about the people that are homeless, about the young children that happen to come up?

Ms. JOHNSON. We do have people in our institution, a staff who work on that issue specifically. I can address it somewhat, but I'm not the expert. We have worked very hard in a number of areas to try to make sure that programs are there to help particularly families with children who are homeless.

The first thing that we worked very hard on, last year which I noticed was in some newspaper report that I saw this morning was something called the fair housing bill where we for the first time in this country prohibited, among other things, prohibited discrimination in housing for families with children, so that you can no longer be turned away when you go to rent an apartment just because you have children. In most circumstances I think, that's a very important step for all of us in the terms of family's ability to find some kind of affordable housing.

On the health side in terms of homelessness, we do have a special initiative that's part of the community in migrant health center programs that I mentioned; and we're hoping that that program will be much more adequately funded this year because we know that one of the great needs that homeless families face is the cost of health care, that they often have nowhere to go for health care and that it's very difficult for them given the, you know, instability in their residence and so forth to find some providers. And we're hoping that that program will be fully funded, indeed, not just for mothers and children, but for other individuals who are homeless.

Senator CONRAD. I'm going to have to shut off this panel because we're about 20 minutes behind now, and given the numbers of people we still want to hear from and we certainly want an opportunity to open it up for further discussion from the audience, so I want to thank this panel very much for your contribution. I appreciate the excellent written testimony that's been provided and call on our next panel.

Mary Deutsch Schneider, the director of the Fargo Regional Office of Legal Assistance of North Dakota. Alice League, the director of Community Action and Development of Dickinson. Urban Weber, the regional manager of North Dakota Job Service in Fargo. Jerry Korsmo, the Southeast Human Service Center in Fargo; and Barb Johnson from People Escaping Poverty in Fargo. For your information, the next panel will be health care providers, people from the community who represent various institutions who actually provide health care in our community and then we're going to have a chance to open it up for your comments and your suggestions and maybe somebody out there has a solution to all of this. Did anybody come here with a detailed solution?

UNIDENTIFIED SPEAKER. That's your job.

Senator CONRAD. That's my job, right. OK. Why don't we proceed with Mary. Welcome.

Ms. SCHNEIDER. Thank you.

Senator CONRAD. Good to have you here. Mary, the director of the Fargo Regional Office of Legal Assistance of North Dakota, and the question before this panel are the problems of access for health care.

STATEMENT OF MARY DEUTSCH SCHNEIDER, MANAGING ATTORNEY, FARGO REGIONAL OFFICE OF LEGAL ASSISTANCE OF NORTH DAKOTA

Ms. SCHNEIDER. Thank you, Senator Conrad, for the opportunity to present testimony today on behalf of low-income elderly and disabled clients served by Legal Assistance of North Dakota.

Many North Dakota citizens, many of my neighbors and yours are one rupture, one relapse, one wreck away from ruin. Many of my clients suffer the daily fear of a call from the hospital or from the school about an accident, an accident for which a child cannot be treated or from which financially a family cannot recover. The poor, those with the least political power, those with the softest sounds when voices are raised in reform and those with the greatest need often for medical care and continuity are those hardest hit by the slam of the door to health care. That door is closed to them because they are either uninsured or underinsured.

Let me put some real life stories with the people that we've had described here today on the previous panel and some of the statistics that you just heard from Kay Johnson. These are all North

Dakota citizens. They're real clients that we've served at Legal Assistance and only a few of the hundreds of people in similar health crises around our 11-county region.

The first is a common scenario. Barb could not get services for one of her two children because she had an unpaid bill at a local clinic. Her solution this time was to switch providers to another health care facility. She doesn't know what she will do when that similar occasion occurs.

We had one client, a man with a catheter who had to take and wash and reuse the bag attached to it because he could not afford his medical bills or the supplies that he needed. This individual's employed part time in the food industry in this area.

We had a middle-aged lady without insurance who was given knee surgery at a local hospital. When it became apparent that she was unable to pay for the knee surgery, she was told that she would not be able to get the staples removed from her knee postoperatively because she did not have insurance and she couldn't afford to pay.

One gentleman was laid off at his job at a large institution in town because he was ill and could not maintain the insurance connected with his employment. He could not afford needed tests. He did not get needed medical care because he did not have insurance. This gentlement qualified for medical assistance shortly before he died of cancer.

An other client had a premature baby as was described from one of the facility providers here today. Of over $300,000 in medical bills, only $43,000 was paid by medical assistance. The financial entanglements, the legal actions have caused considerable hurt and harm to this family and also presumably to the facility involved.

There is a presumption by people commonly I think that all poor people are covered by medical assistance. That is not so in North Dakota. For all members of a single parent three-person household to receive medical assistance the family must have income that's only 57.50 percent of the poverty level or below that.

In addition, most persons from two parent families cannot qualify. Medical assistance does not pay for people between the ages of 21 and 65 in institutions including the State hospital where care is not free in this State.

Poor and non-elderly couples generally cannot qualify for coverage for health care under medical assistance. North Dakota has not elected to exercise options allowed by the Federal governments to cover certain poor pregnant women and young children. It is not opted to provide either income or medical assistance to two parent intact families.

North Dakota is one of 14 States that does not provide medical insurance through medical assistance to SSI recipients. Those individuals have a monthly income currently of $368 a month. For those who do get coverage, they often do not get the coverage that they need. North Dakota has elected under Federal option to provide only 24 of 32 federally permitted services.

Senator Conrad, the Federal government can have a dramatic effect as we know on the poor and uninsured by mandating insurance coverage to specific groups. The recently enacted welfare presence. I add my written recommendations for reform requesting

Federal intervention manifestation of coverage of services to those listed by Kay Johnson and request that we provide assistance to those least able to pay for it themselves.

Thank you for the opportunity and for your concern for low-income elderly and disabled people that you've shown in the past.

Senator CONRAD. Thank you very much.

[The prepared statement of Ms. Schneider follows:]

SENATE BUDGET COMMITTEE
February 13, 1989

Uninsured and Underinsured: The Poverty Population at Risk

By Mary Deutsch Schneider, Managing Attorney
Legal Assistance of North Dakota
Fargo Regional Office

Many North Dakota citizens are one wreck, one rupture, one relapse away from ruin. Many of my clients and our neighbors suffer the daily fear of a call from the hospital or school that there has been an accident--one for which a child cannot be treated, or from which, financially, a family cannot recover.

Those with the least political perception and power, those with the softest sound when voices are raised to reform, and those often with the greatest need for medical care and continuity are those hardest hit by the slam of the portal to health care. The keys to that door are insurance, and these individuals have not enough or none.

The uninsured and underinsured transect and transcend all age and gender groups. Lack of insurance spans individuals literally from the cradle to grave, affecting those victimized by a lack of prenatal care as well as those whose savings are eliminated by a nursing home stay.

Though the extent of their needs are not easily identifiable, the group characteristics of the uninsured or underinsured are

- Many people below the poverty level, including women and children, who cannot qualify for Medical Assistance.
- The mentally ill who cannot obtain insurance adequate to cover extended institutional treatment.
- The working poor, particularly women heading single-parent households.

° The elderly who don't qualify for Medicare, who can't afford to supplement it, or who have become impoverished from medical bills or nursing home care.

Let me put some real people's stories with those categories. All are clients which we have served at Legal Assistance and are only a few of many hundreds in our eleven-county region suffering various health care crises:

- Barb could not get services for one of her two children because of an unpaid bill at a local clinic. She switched service providers but doesn't know what she will do when the same situation arises at the new facility.
- One man with a catheter had to wash out and reuse the connected bag because he couldn't afford to pay incurred medical bills and supplies. He's employed in the food industry.
- A middle-aged lady without insurance was given knee surgery at a local hospital. When it became clear she would be unable to pay for the surgery, she was told that the staples would not be removed post-operatively because she had no insurance and no money.
- One gentleman was laid off his job because he was ill and could not maintain the insurance connected with his employment. He could not afford needed tests and medical treatment. He did qualify for Medical Assistance shortly before he died of cancer.
- Another client had a premature baby. Of over $300,000 in medical bills, $43,000 was paid by Medical Assistance. The unpaid balance has caused serious legal entanglements and financial hardships for the family as well as, presumably, for the hospital.

There is a common misconception in this state that the middle class are the people most uninsured or underinsured. There is a presumption that the poor are covered by Medical Assistance. Not so. A significant number of people of all ages whose incomes are below the poverty line can neither qualify for Medical Assistance nor afford insurance. All the people I described were below the poverty line. All were underinsured or uninsured by Medical Assistance. So are a number of other groups.

- For all members of a single-parent family of three to receive Medical Assistance, the family must have income, after some limited deductions, of less than 57.6% of the poverty line.
- Most members of poor two-parent families cannot qualify.
- Medical Assistance does not pay for people between the ages of 21 and 65 in institutions, including the State Hospital where care is not free.
- Low income or no income single individuals are not covered unless elderly, or determined disabled for twelve months or longer.
- Poor non-elderly couples generally cannot qualify.
- North Dakota has not elected to exercise options allowed by the federal government to cover certain poor pregnant women or young children. It has not opted to provide either income or Medical Assistance benefits to unemployed two-parent families.
- North Dakota is one of fourteen states that does not extend Medical Assistance eligibility to all its SSI recipients.
- North Dakota has elected not to pursue the federal option to extend Medical Assistance coverage to elderly and disabled people with incomes up to the poverty line.
- For those who do get coverage, this state provides only 24 of the 32 federally permitted services.

The federal government can have a dramatic affect on the poor and uninsured by mandating coverage to specific groups. The recently enacted welfare reform law is an example of such a strong federal presence. There will be phased in coverage by 1990 of pregnant women up to the poverty line for pregnancy-related services and children six or under if the household income is below the poverty line. Such coverage was an optional service which North Dakota did not pursue. Unemployed two-parent households up to the AFDC level (considerably below the poverty line) must be covered beginning in 1990. North Dakota had declined to allow such benefits to unemployed households until federally mandated. An additional mandate includes a six-month extension of Medical Assistance benefits for some AFDC recipients who become ineligible because of income from employment. An additional six-month extension for those individuals may be given if certain requirements are met.

Despite the improvements in health care coverage for some poor persons as a result of welfare reform, there are many continuing problems with gaps in the population covered by public insurance. With the exceptions of unemployed parent coverage and expansion of coverage for pregnant women and some children, the individuals and situations cited here would still not be covered by health care insurance.

In addition, even after welfare reform, a state may choose to place severe restrictions on coverage for the newly covered groups, including limitations on most non-accute care benefits, skilled nursing facility services, home health services, physical therapy, private duty nursing, certain diagnostic screening, prescriptive and rehabilitation services, in-patient psychiatric services, hospice care, respiratory care, and intermediate care facility services.

There are actions the federal government can take to lessen or alleviate the uninsured and underinsured dilemma:

1. Develop better data on the numbers and types of individuals who are uninsured or underinsured.
2. Increase federal incentives to states to expand Medical Assistance coverage.
3. Increase federally mandated coverage under Medical Assistance.
4. Mandate pro-rated fringe benefits, including health insurance, for part-time and temporary workers.
5. Control health care costs both for the uninsured and those who must purchase insurance for themselves or their employees.
6. Develop universal health insurance access. This may be done in the form of national health insurance, a pool for the uninsured, subsidization of HMO's or other means.
7. Create incentives for states like North Dakota to develop a state health insurance entity like it has a state mill, and a state bank.
8. Develop or expand programs such as Hill-Burton which require provision of free or low cost medical care to individuals who can not afford to pay, as a condition of receiving federal funds.

In 1948, the United Nations issued a universal declaration of human rights which included the precept that "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including . . . medical care . . . and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." Over 40 years later, we still have a long way to go.

Senator CONRAD. Next we will hear from Alice League, the director of Community Action and Development in Dickinson. Welcome, Alice.

STATEMENT OF ALICE LEAGUE, EXECUTIVE DIRECTOR, COMMUNITY ACTION AND DEVELOPMENT PROGRAM

Ms. LEAGUE. Thank you, Senator. I think I get the award for the second farthest person to come, 300 miles.

Senator CONRAD. You get to talk longer too, then.

Ms. LEAGUE. As I begin my testimony, I would like to review some of the statistics from a study published by Justice For All with Michael Herington as author to give us an overview of the poverty in America. Who are the poor? In recent years the fastest growing group among the poor is the working poor, not the welfare poor. In 1975 6.5 million working people fell below the poverty line. By 1983 that number had risen to 9.4 million. Most of the poor people in the United States do not receive welfare payments, only one-third of the 32.4 million people in this country receive public assistance commonly known as welfare. In 1986 20.5 percent of all children lived below the poverty level. The farmers' poverty rate in 1986 was 19 percent as compared to 13 percent in non-farm America. In North Dakota the incidence of poverty also appears to be on the increase. North Dakota has experienced an economic downturn in the last 7 years, at least in part to the reduction of oil prices and the repressed agriculture economy. The decline of North Dakota's primary industries has pushed many working further into the ranges of poverty.

The divorce and separation has increased significantly in recent years. The number of children affected by divorce rose from 1,250 to 2,500 in the 20 year period for 1965 to 1987.

Out of wedlock births have also increased especially among older women from 1978 to 1986. Out of wedlock births increased an average of 61.5 or 5.4 percent a year. In 1987, excuse me, 1986 there were 4,887 families receiving AFDC benefits; 12,380 households received food stamps. From 1985 to 1986 alone the food stamp caseload increased 12 percent. While the number of farmers receiving benefits rose in that same time period by 58 percent.

In 1986 a total of 18,370 households received fuel assistance. In 1986, 60.8 percent of all heads of households filing income tax in the State of North Dakota had an adjusted gross income of less than $15,000.

In a recent study conducted by UND almost 22 percent of the work force in small North Dakota towns is underemployed. This is twice the national average.

In addition to the working poor, the uninsured from my perspective, one of the barriers in helping families move from public assistance to self-sufficiency is the lack of affordable health care. As an advocate for assisting low-income people to being economically independent, a subsidized group health insurance demonstration project is being proposed.

For the past 6 years I have administered a self-funded employee benefit plan for 22 community action agencies in Federal Region 8. The self-employment plan was implemented in 1983 as a way to reduce employee insurance costs for member agencies and enable agencies to have more grant funds to provide client services as the annual appropriations decreased.

In the last couple of years, many of our agencies in the region have developed and implemented a self-sufficiency program. Self-sufficiency is a people-helping program that enables familes and individuals who are experiencing financial difficulties to work toward economic independence. The case management approach provides support and guidance to assist in problem solving, goal setting, career exploration, emergency assistance and personal issues. These programs enable persons on public assistance programs to bcome self-sufficient.

Some of the barriers to the success of these programs have been finding employment that pays more than $3.35 per hour and finding a job with employer-provided insurance benefits. This is the real dilemma for rural areas especially with a constant increase in health care availability and costs as well as a decrease in population due to out-migration.

Therefore, the Regional Association responds to this critical need for affordable health care has written a grant to the Office of Community Services, the Northwest Area Foundation to conduct a demonstration project that would provide a subsidized health care plan for low-income persons in a six-State area. This would be a demonstration partnership project between the Office of Community Services, Northwest Area Foundation, Blue Cross of North Dakota, UND Center for Rural Health and Region 8 CAA Association.

The project would allow individuals and families to enroll in the plan with the participant paying a portion of the health premium according to their ability to pay. The funding sources would provide additional premium needed during the demonstration period. An analysis of the benefit usage of health claims by the participants would be completed by Blue Cross.

It is a common myth that low-income means less healthy and, therefore, a greater insurance risk. It is my opinion that this is not true, especially in rural America and more specifically in rural North Dakota. If funded, the information derived from the demonstration project could be provided to State legislatures for implementation of ongoing health insurance program for low-income persons. At this point in time we have not been advised of funding, maybe the grant will be funded as of April of 1989.

In the meantime, the welfare reformate was passed that required the State to provide medical assistance for the first 6 months after one is no longer eligible for AFDC. The second 6 months will be provided if the participants can pay a portion of the premium based on income. This may be sufficient support to add economic independence for the first year of not utilizing AFDC, but my concern is what will happen at the end of that first year given the situation in rural America.

I applaud the Congress for beginning to implement welfare reform, however, in rural North Dakota our problems are far different than from the East Coast to the West Coast. Jobs are few and far between. They are usually at minimum wage and at the present time most of the available jobs are part time. Most employers in western North Dakota at least do not provide any fringe benefits. Child care is costly. In a rural area there is no public transportation, therefore, one must have a vehicle to get to work. In my city, the low-income housing units are on one side of town, approximately six miles from any of the work stations.

Let me review a typical budget of a single mom with two preschool children that has just found employment. Her salary would most likely be from $3.35 to $4.50 per hour or an income of $580 to $780 per month with no benefits provided. Her average monthly expenses would be as follows: Child care $320 a month; food, $200 a month; housing, $225 per month; health insurance, if she could find it, at $175 per month; transportation, $100 a month, that totals $1,020. With these basic necessities she would come up short from $440 to $240 a month. This doesn't include the money that she would need for clothing for the new job or her children or money for crisis situations or additional expenses needed for maintaining an apartment or a home or all those little things that those of us just take for granted. Therefore, if she does decide to go to work, health care costs are usually the last item to include in the budget. Trying to make a decision about which necessity is most important puts enormous stress on our single family and our working poor today.

As I work with clients on a daily basis, it becomes clear to me that the system must be changed. We must encourage persons to work and support themselves. However, we must have employment opportunities that will pay enough to meet their basic needs. If the wages cannot be increased, which is true mostly in western North Dakota, or adequate jobs created to meet the needs of the unemployed and the underemployed, especially in rural America, a system of continued support must be implemented. Let's encourage the unemployed person to take the minimum wage job and provide supplemental support of child care and medical benefits until their income reaches 200 percent of poverty level. Let's implement a health insurance program with small deductibles for all working persons with the premium based on their ability to pay.

Having an increasing number of people who are poor or are near-poor because of unemployment or underemployment is not the foundation upon which a strong society is built. In order for the foundation of rural America to remain strong, the system must be changed to encourage independence rather dependency by implementing a comprehensive support system.

Senator CONRAD. Thank you very much.

[The prepared statement of Ms. League follows:]

Testimony prepared for the U.S. Senate Budget Committee Hearing

Fargo, North Dakota - February 13, 1989

by Alice League, Executive Director, Community Action and Development Program, Dickinson, N.D.

"The Plight of the Uninsured in North Dakota"

As I begin my testimony, I would like to review some statistics from a study published by Justice for All with Michael Harrington as author to give us an overview of the poverty in America.

Who are the poor?

--In recent years, the fastest growing group among the poor is the working poor, not the welfare poor. In 1979, 6.5 million working people fell below the poverty line. By 1983, that number had risen to 9.4 million.

-- Most of the poor people in the United States do not receive welfare payments. Only one-third of the 32.4 million poor people in this country receive public assistance commonly known as welfare.

-- Children constitute the poorest age group in the United States. In 1986, 20.5 percent of all children lived below the poverty line.

-- Farmers have a higher poverty rate than the rest of the country. The poverty rate on the farm in 1986 was 19 percent as compared to 13 percent in nonfarm America.

-- The gap between the poor and rich American families is widening. In 1986, the poorest fifth of all U.S families received 4.6 percent of the total national family income. At the same time, the wealthiest fifth received 43 percent of the total.

In North Dakota the incidence of poverty also appears to be on the increase. North Dakota has experienced an economic downturn in the last seven years due, at least in part, to the reduction in oil prices and the depressed agricultural economy. The decline of North Dakota's primary industries has pushed many working poor further into the ranges of poverty.

-- Divorce and separation has increased significantly in recent years. The number of children affected by divorce rose from 1250 to 2500, in the twenty year period from 1965-1987.

-- Out-of-wedlock birth have also increased especially among older women. From 1978 to 1986, out-of-wedlock births increased an average of 61.5, or 5.4 percent, a year.

-- In 1986, 4,887 families received AFDC benefits.

-- 12,380 households received food stamps. From 1985-1986 alone, the food stamp caseload increased 12%, while the number of farmers receiving benefits rose in that same time period by 58%.

-- In 1986, a total of 18,370 household received fuel assistance.

-- In 1986, 60.8% of all head of households filing taxes in the state had an adjusted gross income of less than $15,000.

-- According to a recent survey by Dickinson Job Service, Dickinson women now comprise 50.6 percent of the total employment. Part-time employees accounted for 35.1 percent of Dickinson's total employment and 67.9% of the part-time workers were women.

-- In a recent study conducted by UND, almost 22 percent of the work force in small North Dakota towns is underemployed. This is about twice the national average.

-- And according to a recent survey by the N.D. Health Department, one in ten residents do not have health insurance. The uninsured are relatively young, employed at or near full-time in unskilled or semiskilled occupations, and earn incomes on the lower end of the scale.

If we take into account these facts about a large portion of the state's population, it's no wonder that an increasing number of residents do not have health insurance. Their budgets just will not accomodate the rising cost of health insurance.

In addition to the working poor that are uninsured, from my perspective, one of the barriers in helping families move from public assistance to self-sufficiency, is the lack of affordable health care. As a advocate for assisting low-income people to become economically independent, a subsidized group health insurance demonstration project is being proposed.

For the past six years, I have administered a self-funded employee benefit plan for 22 Community Action Agencies located in North Dakota, South Dakota, Montana, Wyoming, Colorado and Utah for the Region VIII CAA Association. The self-funded plan was implemented in 1983 as a way to reduce employee insurance costs for member agencies and enable agencies to have more grant funds to provide client services as the annual appropriations decreased.

In the last couple of years, many of the agencies in our region have developed and implemented self-sufficiency programs. Self sufficiency is a people-helping program that enables families and individuals who are experiencing financial difficulties to work toward economic independence. The case management approach provides support and guidance to assist in problem-solving, goal setting, career exploration, emergency assistance and personal issues. These programs enable persons on public assistance programs to become self-sufficient.

Some of the barriers to the success of these programs, has been finding employment that pays more than $3.35 per hour, and finding a job with employer provided insurance benefits. This is a real dilemma for rural areas especially with the constant increase in health care availability and costs, as well as the decrease in population due to out migration.

Therefore, the regional association, in response to this critical need for affordable health care, has written a grant to the Office of Community Services and the Northwest Area Foundation to conduct a demonstration project that would provide a subsidized health care plan for low income persons in a six state area. This would be a demonstration partnership project between the Office of Community Services, Northwest Area Foundation, Blue Cross of North Dakota, the UND Center for Rural Health, and the Region VIII CAA Association.

The project would allow individuals and families to enroll in the plan with the participant paying a portion of the health premium according to their ability to pay. The funding sources would provide the additional premium needed during the demonstration period.

An analysis of benefit usage of health claims by the participants will be completed by Blue Cross. It is a common myth that "low income" means "less healthy" and therefore a "greater insurance risk". It is my opinion that this is not true especially in rural america and more specifically rural North Dakota.

If funded, the information derived from the demonstration project could be provided to the state legislatures for implementation of an ongoing health insurance program for low income persons. At this point in time, we have not been advised from the funding sources of grant approval. The Office of Community Services has advised us that announcement of grant awards will not be until April, 1989.

In the mean time the Welfare Reform Act was passed that will require the state to provide medical assistance for the first six months after one is no longer eligible for AFDC. The second six months will be provided if the participant can pay a portion of the premium based on income. This may be sufficient support to aid economic independence for the first year of not utilizing AFDC, but my concern is what will happen at the end of that first year given the situation in rural america?

I applaud the Congress for beginning to implement welfare reform. However, in rural North Dakota our problems are far different than on the East or West coast. Jobs are few and far between. They are usually at minimum wage and at the present time most of the available jobs are part time. Most employers in western North Dakota do not provide any fringe benefits. Child care is costly. In a rural area, there is no public transportation, therefore one must have a vehicle to get to work. In my city, the low income housing units are on one side of town, approximately six miles from the majority of work stations.

Let me review for you a typical budget of a single mom with two pre-school age children that has just found employment. The salary will most likely be from $3.35 to $4.50 per hour or an income of $580 to $780 per month with no benefits provided. Her average monthly expenses would be as follows:

Child care	$320.00	per month
Food	200.00	per month
Housing	225.00	per month
Health Insurance	175.00	per month
Transportation	100.00	per month
Total	1020.00	per month

With these basic necessities, she would come up short from $440 to $240 per month. This doesn't include the money she will she will need for clothing for the new job or for her children, or money for crisis situations or additional expenses needed for maintaining an apartment or home or money for the little things most of us take for granted.

Therefore, if she does decide to go to work, health care costs are usually the last item to include in the budget. Trying to make a decision about which necessity is most important puts enormous stress on our single parents today. This also includes the working poor families.

As I work with clients on a daily basis, it becomes clear to me that the system must be changed. We must encourage persons to work and support themselves. However, we must have employment opportunities that will pay one enough to meet their basic needs.

If the wages can not be increased or adequate jobs created to meet the needs of the unemployed and the underemployed especially in rural america, a system of continued support must be implemented.

Let's encourage the unemployeed person to take the miminum wage job and provide supplemental support of child care and medical benefits until their income reaches 200% of poverty level. Implement a health insurance plan with small deductibles for all working persons with a premium based on their ability to pay.

The results or benefits of implementing a comprehensive support system to all persons below 200% of the poverty level would:

-- eliminate a common barrier for AFDC dependency in rural america.

-- assist individuals to become self-sufficient and independent families.

-- reduce medical expenditures and public assistance dependency.

-- solidify the family structure.

-- allow low income individuals access to health care services.

Having an increasing number of people who are poor, or are near poor because of unemployment or underemployment, is not the foundation upon which a strong society is built. In order for the foundation of rural america to remain strong, the system must be changed to encourage independence rather than dependency by implementing a comprehensive support system.

Senator CONRAD. Next we will hear from Urban Weber, the regional manager of North Dakota Job Service in Fargo, Urban.

STATEMENT OF URBAN WEBER, REGIONAL MANAGER, NORTH DAKOTA JOB SERVICE

Mr. WEBER. Since I'm from right here in Fargo, I'll stay real brief.

The primary purpose is to provide some additional statistical data for your consideration, Senator Conrad. Some of the trends that we are seeing in our current job market include—in the city of Fargo we did a survey, the total employment in Fargo was 51,972. Of that employment, 15,729 is part time or 30 percent. When you look at some of the hig-risk groups and in particular females, total female employment 24,676 total part-time female employment is 1,020 or 40 percent.

Some additional statistics that might be of interest to you, 34 percent of our hourly employees have no insurance, that's either full time or part time hourly employees. An additional 16 percent of those hourly employees paid 50 percent or more of their insurance premium. 18 percent of that salaried employee had no, had no insurance for their spouses. In Grand Forks 39 percent of the hourly employees had no employee plan and 48 percent had no dependent plan. Statewide that breaks out to 51 percent of the hourly and 50 percent of the hourly had no dependent plan. We estimate statewide approximately three of ten positions currently are part time. In Fargo 41 percent of female total populations working in—are working in part-time positions. We also estimate that 40 percent of all new job creations is part time, so the problem will get worse as time goes on.

In some industries, service industry for instance, part-time employment amongst females is 65 percent of all female employees. Retail trade at 69 percent of all female employment as part time. Youth and elderly are also very predominant in these industries.

Senator CONRAD. Could I just stop you there and ask, we're talking about a very large percentage of the jobs part time, new jobs being created, some 40 percent. You're talking about the number of women in the work force in various industries, nearly 70 percent part time. Am I correct in assuming that those jobs do not have benefits attached to them?

Mr. WEBER. The majority of them do not.

Senator CONRAD. The majority do not?

Mr. WEBER. Right.

Senator CONRAD. Do we have a percentage of what percentage do not have——

Mr. WEBER. In the surveys we've done we have not broken it out in the past in part time and full time. Starting with the surveys in 1989 will be, but it was never that big an issue before, but it seems to be that magnitude now that we will be breaking it down.

Senator CONRAD. All right. Well, thank you very much. I appreciate that addition to the statistical base here. I think it becomes quite clear the kinds of problems that we're facing is one that's not on a trend line that's going to improve, it's going to be more severe given the kinds of developments we see in the job force.

Next we'll hear from Jerry Korsmo of Southeast Human Service Center in Fargo. Welcome, Jerry.

STATEMENT OF GERALD KORSMO, SOUTHEAST HUMAN SERVICE CENTER

Mr. Korsmo. Thank you, Senator Conrad. I too will cut mine short. You have my written testimony, so I will just give a couple of illustrations of situations we've run into.

First of all, we are essentially a mental health center so our services are a mental health center.

Many of our clients locally and statewide do not have any insurance. Just to give you a couple of illustrations of the effect of this, case No. 1 involves a mother with two preschool aged children who request counseling from the center because of depression and family problems resulting from her separation and subsequent divorce. She's employed earning just above minimum wage. During the course of counseling she loses her driver's license because she has a seizure. She had stopped taking her anticonvulsant medications because she could not afford $50 for the medication nor could she afford the laboratory test needed to monitor her blood level. Counseling can help her cope, but basic medical care is needed and inaccessible. If she quit her job, she would be eligible for medical assistance.

The second illustration involves a 27-year-old man with psychiatric illness. He's a college graduate. The young man requires three hospitalizations for acute schizophrenic episodes at a local community psychiatric unit. The first three were covered by his insurance from his previous employer, but because he has been unable to maintain a job and pay the premiums, he is now not covered. He has applied for disability but determination had not been completed as yet.

He has another acute schizophrenic episode and needs a brief 2 to 3 day hospitalization. Even though the service is available in the community, he must be sent 100 miles away to the State hospital again because of lack of personal or third-party resources.

The problems the Human Service Center staff see routinely are the inability to pay for needed non-psychiatric medications results in people not taking them. Clients needing routine physicals similarly don't have them. If laboratory testing is needed, clients without insurance don't have them done. Handicapped individuals who are uninsured or underinsured don't receive needed therapies for such as occupational, physical or speech therapy. Clients who need shortterm psychiatric hospitalizations are unnecessarily sent to the State hospital and then there's a fear of medical crises and bankruptcies in bills.

Thank you, Senator, for this opportunity to testify.

Senator Conrad. Thank you, Jerry. I appreciate that testimony also your excellent written testimony that accompanied it.

[The prepared statement of Mr. Korsmo follows:]

THANK YOU SENATOR CONRAD:

MY NAME IS GERALD KORSMO, I AM THE REGIONAL DIRECTOR OF THE SOUTHEAST HUMAN SERVICE CENTER. I AM HERE THIS MORNING REPRESENTING THE NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES.

THE DEPARTMENT OF HUMAN SERVICES AND REGIONAL HUMAN SERVICE CENTERS PROVIDE A A WIDE RANGE OF SERVICES EITHER THROUGH CONTRACTS AND FINANCIAL SUPPORT OR DIRECTLY TO RESIDENTS OF THE STATE WHO ARE EXPERIENCING VARIOUS PROBLEMS. THROUGH THESE SERVICES WE SEE DAILY THE IMPACT OF INADEQUATE FINANCIAL RESOURCES OR THIRD-PARTY COVERAGE INCLUDING HAVING NO HEALTH INSURANCE OR BEING UNDER INSURED. THIS MORNING I WILL SHARE SOME INFORMATION ON THE EXTENT OF THE PROBLEM, TWO CASE EXAMPLES, AND A SUMMARY OF KEY ISSUES AND CONCERNS THAT STAFF IN OUR HUMAN SERVICE CENTER SEE ROUTINELY FOR CLIENTS WITHOUT INSURANCE.

DURING THE FIRST YEAR OF THE 1987-89 BIENNIUM, SIXTY-FIVE (65) PERCENT OF THE 21,377 CLIENTS SERVED BY THE EIGHT HUMAN SERVICE CENTERS HAD NO HEALTH INSURANCE AND ELEVEN (11) PERCENT WERE TITLE XIX (MEDICAL ASSISTANCE) ELIGIBLE. THE REMAINING TWENTY-FOUR (24) PERCENT, ALTHOUGH INSURED, OFTEN COULD NOT UTILIZE THEIR INSURANCE COVERAGE FOR OUT-PATIENT SERVICES BECAUSE OF CAPS ON COVERAGE, RECIPIENT LIABILITY OR CO-PAYMENT OR SIMILAR DRAWBACKS.

DURING 1988, OF THE 2,690 ADMISSIONS TO THE STATE HOSPITAL, SEVENTY-SIX (76) PERCENT HAD NO HEALTH INSURANCE, ELEVEN (11) PERCENT WERE MEDICARE ELIGIBLE, FIVE (5) PERCENT WERE MEDICAID ELIGIBLE, AND EIGHT (8) PERCENT HAD COMMERCIAL INSURANCE COVERAGE.

BUT WHAT IS THE IMPACT ON PEOPLE AND FAMILIES? I HAVE CHOSEN TWO VERY SIMPLIFIED EXAMPLES TO SHARE WITH YOU. SOME INFORMATION ON THESE SITUATIONS HAVE BEEN MODIFIED TO INSURE CONFIDENTIALITY FOR CLIENTS.

CASE NUMBER ONE INVOLVES A MOTHER WITH TWO PRE-SCHOOL AGE CHILDREN WHO REQUESTS COUNSELING FROM THE CENTER BECAUSE OF HER DEPRESSION AND FAMILY PROBLEMS RESULTING FROM HER SEPARATION AND SUBSEQUENT DIVORCE. SHE IS EMPLOYED EARNING JUST ABOVE MINIMUM WAGE. DURING THE COURSE OF COUNSELING, SHE LOSES HER DRIVER'S LICENSE BECAUSE SHE HAS A SEIZURE. SHE HAD STOPPED TAKING HER ANTI-CONVULSANT MEDICATION BECAUSE SHE COULD NOT AFFORD THE FIFTY DOLLARS PER MONTH FOR THE MEDICATION NOR COULD SHE AFFORD THE LABORATORY TESTS NEEDED TO MONITOR HER BLOOD LEVEL. COUNSELING CAN HELP HER COPE BUT BASIC MEDICAL CARE IS NEEDED AND INACCESSIBLE. IF SHE QUIT HER JOB, SHE WOULD BE ELIGIBLE FOR MEDICAL ASSISTANCE BUT SHE CHOOSES TO WORK.

CASE NUMBER TWO INVOLVES A 27 YEAR OLD WITH A SERIOUS PSYCHIATRIC ILLNESS. A COLLEGE GRADUATE, THIS YOUNG MAN REQUIRES BRIEF HOSPITALIZATIONS FOR ACUTE SCHIZOPHRENIC EPISODES AT A LOCAL COMMUNITY PSYCHIATRIC UNIT. THE FIRST THREE WERE COVERED BY HIS INSURANCE FROM HIS PREVIOUS EMPLOYER BUT BECAUSE HE HAS BEEN UNABLE TO MAINTAIN HIS JOB AND PAY THE PREMIUMS HE IS NOW NOT COVERED. HE HAS APPLIED FOR DISABILITY BUT A DETERMINATION HAS NOT BEEN MADE. HE HAS ANOTHER ACUTE SCHIZOPHRENIC EPISODE AND NEEDS A BRIEF TWO TO THREE DAY HOSPITALIZATION. EVEN THOUGH THE SERVICE IS AVAILABLE IN THE COMMUNITY, HE MUST BE SENT 100 MILES TO THE STATE HOSPITAL. AGAIN, BECAUSE OF LACK OF PERSONAL OR THIRD PARTY RESOURCES.

THE PROBLEMS HUMAN SERVICE CENTER STAFF SEE ROUTINELY ARE:

1. THE INABILITY TO PAY FOR NEEDED NON-PSYCHIATRIC MEDICATIONS RESULT IN PEOPLE NOT TAKING THEM.
2. CLIENTS NEEDING ROUTINE PHYSICALS SIMPLY DON'T HAVE THEM.
3 IF LABORATORY TESTING IS NEEDED, CLIENTS WITHOUT INSURANCE DON'T HAVE THEM DONE.
4. HANDICAPPED INDIVIDUALS WHO ARE UNINSURED OR UNDER INSURED, DON'T RECEIVE NEEDED THERAPIES SUCH AS OCCUATIONAL, PHYSICAL OR SPEECH THERAPY.
5. CLIENTS WHO NEED SHORT-TERM PSYCHIATRIC HOSPITALIZATION ARE UNNECESSARILY SENT TO THE STATE HOSPITAL.
6. FEAR OF MEDICAL CRISIS.
7. BANKRUPTCY/BILLS.

Senator CONRAD. Next we will hear from Barb Johnson, the director of People Escaping Poverty in Fargo. Barb.

STATEMENT OF BARB JOHNSON, PEOPLE ESCAPING POVERTY

Ms. JOHNSON. Thank you, Senator Conrad.

People Escaping Poverty is a project that works to unite and strengthen the voice of lowincome people in our area. And our work organizes low-income people we see on a daily basis the devastation that occurs when people are forced to go without needed medical treatment. And many people come into our office and their big concerns are that they often experience guilt from not being able to afford these services for their children and they live in fear that they're going to be charged with child neglect because they're not going to be able to get their children the needed medical care that they have. They resent the fact that health care isn't accessible to them. Families often are working full time at jobs, but the jobs no longer offer any medical benefits for them or the wages pay such a low amount that they can only take care of the basic needs that their families have.

The majority of the people that we see without medical assistance have been weaned off the Social Service System. They push self-sufficiency, but they never stop to tell the people that self-sufficiency would mean that they lose their medical, their access to medical care.

When we were invited here today we were asked to share some stories that we hear on a regular basis in our office. I'd like to tell you about Doug and Linda Carnegy. Their annual income is $7,000. They have four children. Linda was pregnant and hospitalized in December of 1988 with symptoms of toxemia. She was discharged January 9th and her bill was $10,000. For that family that's over a whole year's income. Their child was born January 5, 1989 and was discharged February 4. His bill for care is over $40,000. He'll have two lifetime disabilities. He'll have a disfunctioning heart and a circulation problem. When he was 2 days old he had an operation to remove a blood clot from his right leg.

They'd like you to know that they can't afford health care. And when the went to apply for medical assistance, they were told that they had to be making more than $7,000 because it would be impossible for them to survive on that amount. Medical assistance could not help them because they found their story too unbelievable, but we hear those stories every day.

I'd like to tell you about Greg and Kathy O'Dell who have three children. The O'Dells are new to the State because Greg was looking for work that would allow more time to take care of his family's needs. The new job kept him on the road 29 days out of the month. The O'Dells had a baby 1 year ago who hasn't been to see the doctor since he was discharged after his birth. He's had none of his immunizations.

They have a 3-year-old child who is prediagnosed with adrenal leukodystrophy when he was 18 months old. One of the symptoms of that disease is that the white matter of your brain deteriorates. When he was diagnosed, they were told he'd have 2 weeks to 1 year to live. They took him to the Mayo Clinic this past November and the Mayo Clinic wasn't sure what was wrong, but they thought it was possible he was having a series of strokes. The trip added to their mounting medical bills. He is no longer seeing a doctor at this time. He is supposed to have an exam every 4 to 5 months to see if the deterioration has increased or if it has stabilized. His last one was done in January of 1988.

They also have an 8-year old child who's learning disabled and speech delayed. He was last seem by the doctor at 4 years old, although he has his immunizations for school. He's supposed to have a hernia operation but they can't afford it. The parents haven't been to see the doctor for routine care either. Kathy hasn't been there for her 6-weeks checkup after the birth of their last child which was over a year ago.

They want you to know they're good parents and that the stress of trying to survive day-to-day left them so exhausted and frustrated that they didn't know where to turn for help. Greg gave up his job to help Kathy take care of the children's needs. And after Greg gave up his job, they qualified for medical assistance. If Greg works, his family will lose the medical care and Greg will not be able to insure them. This family now has medical help, but they're on their way to losing their dignity because they have to deal with the welfare system that strips a lot of your dignity away. if Greg works he's hurting his family, and what's the sense of that?

These people are in need of affordable health care insurance. If we turn our backs on those and them like them, what will result? It is cost-effective to have a healthy society and that's socially responsible to have a healthy society; and I really hope that we can find some way to provide care for these people who need it. Thank you.

Senator CONRAD. Thank you very much for that really moving testimony. I would simply ask this panel, you are in the front lines, you're in the trenches talking to the very people that we're referring here to today, that is those people who are underinsured or uninsured and who we know are in large numbers and numbers that are growing rapidly. Could you give us, any one of this panel, some sense that you have from hearing the stories of these people how rapidly the problem is growing? Do you sense that it's moving very quickly or do you think it's basically stable, we've peaked? What is your sense and maybe we'd start with you, Barb.

Ms. JOHNSON. I think the problems is growing. We don't see any decrease in the need for medical assistance and it has a lot to do with the service sector jobs it creates and not enough pay for people. It doesn't look like the wages are going to go up any extent so that these people are going to be able to afford the health care, and it doesn't look like employers are going to start providing health care and benefits, and it is growing fast.

Senator CONRAD. Alice, what would be your analysis of this?

Ms. LEAGUE. Well, I feel we have a catch-22 situation. I live in western North Dakota where we've had in the service area that I serve 11 counties. We've had 10,000 people out-migration from our part of the State. I see it bothering our economic base, you know, the business people can't give raises, they can't give benefits. I believe the statistic for Dickinson is 90 percent of the businesses do not provide any, any benefit whatsoever.

We recently had a college student that graduated from Dickinson that lived with me who could not find a teaching position. She tried to find three parttime jobs to come up with 40 hours so that she would make—at $3.35 an hour, none of them offered her that.

I see it as real problem for western North Dakota. When I travel across the country with my counterparts in community action, I hear people in the east tell me that they can't find people to take $18 an hours jobs to work on their weatherization crews. In New Hampshire a director said I can't find anybody that will take a job to that. We hear in North Dakota we don't know what an $18 an hour jobs is.

One of the statistics I quoted here 60 percent of the State of North Dakota makes less than $15,000. A family of four, 125 percent of poverty level is 17.5 now. When we're talking about over half of the State, that is just barely existing. The people that we work with, too, that don't even file income taxes, the chronically mentally ill, the developmentally disabled. I see it's a real problem in the State and I'm not sure where to go with it except trying some new situations to providing support. I think that's what we have to do.

Senator **Conrad**. Jerry.

Mr. **Korsmo**. I really have nothing to do to add, Senator, that hasn't been covered already.

Senator **Conrad**. All right. Mary.

Ms. **Schneider**. I think particularly with the demise of the Federal minimum wage bills that we have very little hope for positive change. One exception to that being the State bill that is now being considered for mandatory benefits for part-time employees on a pro rata basis, that should be helpful, but otherwise I see, as the other two speakers did also, a geometrical progression in the problem.

Senator **Conrad**. Well, I want to thank this panel once again for your testimony, also the excellent written testimony which you've provided and I've had a chance to review. It's very useful to the record and I thank you very much for your participation.

Our last panel consists of those who are the providers in our community. Dr. Russell Knutson, the president of Dakota Clinic; Dr. Wally Radke, the president of Fargo Clinic; Mr. Larry Narum, the president of St. John's Hospital; D.D. Wightman, the president of Dakota Hospital; Gary Rudolph, the vice president for finance of St. Luke's Hospital; Dr. Justus Fiechtner, Dakota Clinic; and Jim Austin, the director of administrative affairs of Blue Cross-Blue Shield of North Dakota. I want to welcome this panel. Those who are on the second group, we'd welcome you to sit down in the front perhaps for a way of managing the overload. Again we want to welcome the members of this panel. Thank you very much for participating.

Obviously this is a problem that—in which there is intense interest in the community. We've heard described the problems of exploding health care costs, we've heard described the problems of the uninsured and the underinsured, and we've heard a series of cases of people who are unable to get the kind of health care that they need. And now we want to hear from those who are also in the trenches in the sense that they're the providers of health care and they too are faced with many problems operating in the current environment. So we want to hear their description of what they see occurring and possible suggestions for solutions to some of the problems that we see.

And first we will start with Dr. Russell Knutson, the president of Dakota Clinic of Fargo. Welcome, Dr. Knutson.

STATEMENT OF DR. RUSSELL KNUTSON, PRESIDENT, DAKOTA CLINIC

Dr. KNUTSON. Thank you, Senator Conrad. My statement will have to do principally with some of the problems and observations if I can make about the provision of health care in rural environment and are less directed somewhat less specifically at health care costs, but are certainly germane to the topics that have been discussed here this morning.

I represent the Dakota Clinic in Fargo, a multispecialty group practice of physicians and neurosurgeons comprised of approximately 180 health care professionals practicing at 31 separate locations in eastern North Dakota and western Minnesota. The mission of my organization is to provide high-quality comprehensive health care to our patient population in the most appropriate setting and in the most efficient possible manner. As a provider of health care in largely rural environment, the organization I represent is acutely aware of the difficulties of delivering good quality health care in a rural setting and certainly shares current public concern over health care costs and problems related to the uninsured and the underinsured populations of our region.

During the last decade, our organization has grown from a relatively small group practice of 40 physicians located only in Fargo, North Dakota to its current size practicing over a much larger geographic area. This growth has occurred through affiliation with several existing group practices in nearby communities through development of new medical practice sites in previously unserved locations and through the provision of additional referral services at our central location and at some of the regional centers in the area. Similar developments have occurred with other medical providers in our community and in our State.

Several factors have led to this sort of development. The desire to improve the quality of care and to provide technologically sophisticated services has required expanding our patient population base. The development of new reimbursement programs, specifically capitated plans such as HMO's and their extension to the rural areas of both States have threatened some of the traditional medical practices and it's been felt necessary to develop the capacity to provide a wider range of medical services in order to preserve traditional practice in these rural patterns.

Competition among medical providers has been another factor which has led to the development of larger and more sophisticated medical organizations. Such forms of health care coverage as HMO's have extended the availability of medical services to segments of the population who were previously underinsured or uninsured and hence were not able to avail themselves of medical care because of financial constraints.

The results of this expansion in our organization and others has been to increase the availability of a variety of medical services in rural areas surrounding our community. I would emphasize that this is a third and large measure as a result of competitive factors among private and medical providers.

I'd like to make several observations relative to the provision of health care in rural areas based on this experience. Specialty care is being made more accessible to rural areas by the means of having specialists travel to regional rural locations and centers. The quality of such services has certainly been enhanced by providing increased numbers of specialists and providing improved facilities needed to provide certain secondary and tertiary health services. Efforts by my organization and others to increase the availability of physicians and other professionals in smaller communities has to some extent been successful in the past few years. These efforts continue.

As a result of these developments, we found in our organization that the number of patient encounters has been steadily increasing over the past several years despite the fact that the population in our service area is stable or perhaps declining. In addition, the volume of referral services provided in the Fargo-Moorhead community is also increasing, again within a relatively population stable base. This development suggests that there is increased utilization of services as these services have been made more readily available and as the extension of reimbursement programs has made health care more affordable to citizens in our area.

I have some comments on some of the difficulties that we encounter in providing medical services. It's becoming increasingly difficult to attract health care professionals to practice in rural communities because of considerations in practice convenience and life-style and economics. Geographic factors, also deter physicians from elsewhere in the United States from moving here to practice. Reimbursement policies have created financial disincentives for doctors to locate in rural midwestern areas such as ours. Medicare reimbursement rates for many services are significantly lower in the midwest than elsewhere in the country.

Medicaid reimbursement, affecting a significant portion of some rural counties, the population in some rural counties often covers only a fraction of provider costs. HMO plans while encouraging greater utilization of medical services have thus far in general not covered the cost of providing those such services, have created real strains for providers. These policies have increased the difficulty we have in recruiting physicians to this area. While providers in this area are adversely affected by some reimbursement rates relative to their parts of the country, we still must compete in a national market for the services of physicians and other health care personnel.

Another problem is decreasing Federal and State support for medical training programs which threatens to reduce the supply of physicians available in this area. A good illustration of this trend is the recent decision by the State of North Dakota to eliminate funding for the family practice residency training program in Fargo. This program which has been very effective providing well-trained primary care physicians to our area is now funded by the private hospitals in the Fargo-Moorhead community. The currently proposed reduction in medicare allowance for medical education and hospital reimbursement will almost certainly close this program if enacted, eliminating one of our best sources of primary care physicians. The loss of such programs as this will reduce an already inadequate supply of physicians willing to practice in rural communities. Underserved areas will be adversely affected by future shortages of health care personnel.

In light of these concerns, I would have a few comments regarding pending in future legislation. It appears that a major public policy decision regarding the provision of health care benefits to the entire population is pending. As providers attempting to fulfill our role of serving the health care needs to the population, we believe that the provision of quality health care to all of our citizens is an appropriate public goal. Such a decision carries with it the necessary recognition that providing adequate care to a larger portion of the population will necessarily lead to increased total health care costs. I believe that that is largely what accounts for the rise in health care costs which we've seen over the past 20 years. We are providing better care to more people.

A decision to expand the scope of health care without services is a common decision to improve funding for these services will simply worsen the existing strain on providers. Some specific comments about reimbursement policies that are pertinent in our part of the country, one, correct the differences in reimbursement rates between major urban centers and smaller urban communities and rural areas. Two, eliminate disparities and reimbursement levels among various geographical areas in the country, with the extent that such differences are not realistically related to the cost of providing such services. Continue to provide for the support of training programs for physicians and other health care personnel. Strengths in this support are needed to eliminate shortages of manpower. Structure future policies to support continued provision of services by private vendors with appropriate regulations and through cooperative efforts between governmental programs and private initiatives.

To date, although many needs are not filled, it is our opinion that a healthy degree of competition among private providers and a desire by those providers to improve the quality and expand the scope of health services has resulted in enhanced access to and quality of these services. We submit that this has been an appropriate development in provision of health care services in this region, and such activities should be encouraged by future policies.

Thank you very much for this opportunity to discuss these issues.

Senator CONRAD. Thank you, Dr. Knutson.

[The prepared statement of Dr. Knutson follows:]

STATEMENT

CRISIS IN RURAL HEALTH CARE
Rising Health Costs and Problems of the Uninsured

Representing: Dakota Clinic, Ltd., Fargo, North Dakota.

Presented at: Senate Budget Hearings, February 13, 1989, Fargo, North Dakota, sponsored by the office of the Honorable Kent Conrad, United States Senator.

I. INTRODUCTION

My testimony is as a representative of Dakota Clinic, Ltd., a multi-speciallty group practice of physicians and oral surgeons comprised of approximately 180 health care professionals practicing at 31 locations in eastern North Dakota and northwestern Minnesota.

The mission of Dakota Clinic, Ltd. is to provide high quality comprehensive health care to our patient population in the most appropriate setting and in the most efficient manner possible.

As a provider of health care in a largely rural environment, the organization I represent is acutely aware of the difficulties of delivering good quality health care in a rural setting and shares the public concern over health care costs and problems related to the uninsured and underinsured populations in our area.

II. RECENT HISTORY OF DAKOTA CLINIC, LTD.

During the past decade, Dakota Clinic, Ltd. has grown from a group practice of 40 members located in Fargo, North Dakota to its present size within a much larger geographical area. This growth occurred through affiliation with several existing group practices in nearby communities, through development of new practice sites in previously unserved locations and through the provision of additional referral services at our central location and at some of the regional medical centers in the area.

Similar developments have occurred with other medical providers in this region.

Several factors led to these changes:

A. The desire to improve the quality of care and to provide technically sophisticated services required expansion of the patient population base.

This chart right here is really the crux of the problem. This chart here shows our actual rate increases from 1984 to 1988. You can see that in 1984 almost 10 percent and 1985 above 10 percent and 1986, about 7 percent, in 1987 almost 10 percent and 1988 almost 10 percent. Those rate increases, if you look at the darker green would have been one-third if the Federal government was paying its share. That's the main problem. By not paying what it costs us to treat the medicare and medicaid patients, we can't possibly provide the quality care, we can't possibly keep our rate increases down and, in fact, those rate increases are meaningless because individual insurance companies are not paying on a charge basis either.

The problem that we have, and really if we look at what we need from the Federal government is a recognition, that if individuals are going to have coverage, the coverage has to be paid for in some way. If individuals feel they're covered, they expect to have quality care and expect to have that care paid.

We have a bill right now or we have an indication that the new administration is looking at cutting $5 billion out of the Medicare Program. Just listening to a show on television the other day, a representative of the Bush administration indicated that that's going to come primarily from providers. Well, every one of us is impacted by that. Every one of us that pays their own health care costs or every one of us that pays our insurance premium is impacted by that, because if the Federal government will not pay its share, somebody has to. It's simple economics.

Hospitals have to bring in as much as they spend. If they don't bring that amount in, they don't exist. Over 80 hospitals last year went out of business throughout this country. Most hospitals in this country do not make a profit. They don't bring in more than they spend. Over a period of time, they don't exist any longer. So we have to ask ourselves what we're willing to pay for. A number of individuals here have made some very good points.

In closing, I'd like to just say that what we'd really like you to fight for, Senator, is to have full funding of the medicare Program and have the government recognize that if we can't have the market basket increases that we we're talking about, at least we can make some dent towards that problem that exists. Thank you.

Senator CONRAD. Thank you, Mr. Rudolph.

[The prepared statement of Mr. Rudolph follows:]

B. The development of HMO's and similar practice plans and their extension into the rural areas of Minnesota and North Dakota threatened traditional medical practices and necessitated developing the capacity to provide a wide range of medical services in order to preserve traditional practice and referral patterns.

C. Competition among medical providers was another factor which led to the development of larger and more sophisticated medical organizations.

D. New forms of health care coverage such as HMO plans have extended the availability of medical services to segments of the population who were previously unserved or underserved because of financial constraints.

The result of the expansion by Dakota Clinic, Ltd. and other providers has been to increase the availability of a variety of medical services in the rural areas surrounding the Fargo-Moorhead community. I would emphasize that this has occurred in large measure as a result of competition among private providers.

III. RESULTS OF RECENT EXPANSION

Several observations relative to the provision of health care in rural areas can be made based on the experience of the providers in this area:

A. Specialty care is being made more accessible in rural areas by having specialists travel to rural locations.

B. The quality of such services has been enhanced by providing increased numbers of specialists and by improving the facilities needed for certain secondary and tertiary health care services.

C. Efforts to increase the availability of physicians and other professionals in smaller communities has, to some extent, been successful. These efforts by our organization and others continue.

As a result of the above mentioned efforts, we have found that the number of patient encounters in our organization has been steadily increasing despite the fact that the population in our service area is stable or declining. In addition, the volume of referral services provided in the Fargo-Moorhead community is increasing, again, within a stable population. This suggests that there is increased utilization of services as they have become more available and as the extension of reimbursement programs has made health care more affordable to citizens in rural areas.

IV. OBSERVATIONS REGARDING THE DIFFICULTIES IN PROVIDING MEDICAL SERVICES IN A RURAL SETTING:

A. It is becoming increasingly difficult to attract health care professionals to practice in rural communities because of considerations of practice convenience, lifestyle and economics. Geographical factors also deter physicians from elsewhere in the country from moving here.

B. Reimbursement policies have created financial disincentives for doctors to locate in rural midwestern location such as ours.

1. Medicare reimbursement rates are significantly lower in the midwest than elsewhere in the country.

2. Medicaid reimbursement, affecting a significant population in some rural counties, often covers only a fraction of actual provider costs.

These policies increase the difficulty we have in recruiting physicians to this region. While providers in this area are adversely affected by reimbursement rates relative to other areas, we must compete in a national market for the services of physicians and other health care personel.

C. Decreasing federal and state support for medical training programs threatens to reduce the supply of physicians available to this area.

An illustration of this trend is the recent decision by the state of North Dakota to eliminate funding for the family practice residency program in Fargo. This program, which has been very effective in providing well-trained physicians to the area, is currently funded by the local private hospitals. The proposed reduction in Medicare allowance for medical education in hospital reimbursement would almost certainly close this program, eliminating one of our best sources of primary care physicians.

The loss of such programs as this will reduce an already inadequate supply of physicians willing to practice in rural areas. Underserved areas will be the first to be affected by future shortages of health care personel.

V. RECOMMENDATIONS:

In light of the above concerns, I submit the followings comments regarding future legislation:

A. It appears that a major public policy decision regarding the provision of health care benefits to our entire population is pending. As providers, attempting to fulfill our role of serving the health care needs of the population, we believe that provision of quality health care to all of our citizens is an appropriate public goal.

Such a decision carries with it the necessary recognition that providing adequate care to a larger population will necessarily lead to increased total health care costs. A decision to expand the scope of health care services without the concomitant decision to improve funding for these services will simply worsen the existing strain on providers.

B. Specific suggestions regarding reimbursement policy:

1. Correct the differences in reimbursement rates between major urban centers and rural areas.

2. Eliminate disparities in reimbursement levels among various geographical areas, to the extent that such differences are not realistically related to the cost of providing services.

3. Continue to provide for the support of training programs for physicians and other health care personel. Strengthen this support where needed to eliminate shortages of manpower.

4. Structure future policies to support continued provision of services by private vendors, with appropriate regulations and through cooperative efforts between governmental programs and private initiatives.

To date, although many needs remain unfulfilled, it is our opinion that a healthy degree of competition among private providers and a desire by those providers to improve the quality and expand the scope of health services has resulted in enhanced access to and quality of these services. We submit that this has been an appropriate development in the provision of health care services in this region and that such activities should be encouraged by future policies.

Thank you for this opportunity to discuss these issues.

Russell P. S. Knutson, M. D.

RPSK:kl

Senator CONRAD. Let me just intercede with a question if you might, because as I was listening, the question that kept going through my mind, I sense we're almost talking past each other. We've got this explosion of health care costs, the chart that we showed earlier, clearly not sustainable. There's no way we can triple by the year 2000 or double by 1995 given what we're hearing from those who have to pay out of their own pocket and, frankly, given the Federal government's situation which is extremely serious.

The budget situation facing this country, far more serious I think than generally recognized, and yet the trend continues of increasing health care costs, double digit rates. We're now spending about 11 percent of our gross national product on health care. We in 1988 were at some $500 billion for the total health care bill in this country, $550 billion I believe is the number. Just to put that in perspective, in that same year we spent on our defense, which is the biggest part of our Federal budget, $290 billion. We spent about $220 billion on Social Security. And the question that comes to my mind listening to the testimony is where does it stop, and what do we do to contain this explosion, from your perspective as a provider? At some point we're going to have a breakdown and I sense when we talk about 37 million uninsured and hear some of the cases we've heard today, what do we do, from your perspective? How do we solve these problems?

Dr. KNUTSON. I don't know that I have solutions. I believe that we're not approaching a breakdown; we've already reached that point. If our effort is to continue to provide the quality and level of health care services that we've become accustomed to, then cost, increasing costs are inevitable. And I think the real decision, and this is my private opinion, not as a representative of any organization, that it is a public decision to decide how much health care are we going to have, at what level of quality and for what portion of the population, and are we going to be willing to pay for it? I believe that's the real question and it underlies all of the things that we're talking abut this morning.

Senator CONRAD. Let me probe an area that I apologize for if it's uncomfortable, but I think we've got to address the question. It was raised by the insurance commissioner, I believe perhaps others. Mr. Pearson, I think raised the issue as well. They raised an issue of a cancer treatment facility that we would have two. As I recall the number here and the testimony given, $8 million apiece and they talked about that would be two treatment centers in this community. There was an earlier discussion of MRI's which apparently we have several of. From your perspective, is that duplication of services justified in a community? Is it something we can afford? Is there some way for us to structure a situation in which we have savings, perhaps only have one facility and yet not put the institutions at such a competitive disadvantage that they can't survive?

Dr. KNUTSON. I think I can make some comments relative to that. First of all, at the present time in this community those highly sophisticated and expensive technical services are in demand and they are meeting the demand. We are not at this point seeing lack of utilization of those services. So in our current environment they are being utilized.

Given the current State of our medical care reimbursement system and some of the things I eluded to in terms of the development of individual provider organizations, there is a competitive climate and the competition is expressed by provision of services rather than cost factors. That has been a very real factor in the development of some of these services.

Senator CONRAD. Would you explain that a little bit more?

Dr. KNUTSON. May I explain that to you? Capitation payment programs, HMO's specifically, as they have developed will contract with providers to provide a wide range of services. As a provider, one response to that in order to not be eliminated from the possibility of such market share, if you will, is to make sure that we have the available facilities to provide the services required. That's been one aspect of developing some of these.

I'd like to make a couple of other comments because the highly sophisticated and expensive technological equipment is a focus and perhaps a symbol for some of the things we're concerned with. Ten year ago in this State and community there was a great public discussion over whether or not computerized tomographic x-ray scanners should be tightly regulated or to be allowed to develop as private factors would allow them.

Now, I believe I heard this morning whereas there was one such scanner 10 years ago, there are 17 now. That technology became so useful in providing good medical care that it became very quickly almost a necessity for most medical providers to have. It's become a very useful tool in providing good medical care. I believe the same thing will prove true of a later generation of diagnostic equipment which was eluded to the MRI scanners. I believe they will have such beneficial impact on the practice of good quality medical care that we are already very quickly finding that they're an almost indispensable tool.

The third comment I would have regarding the why can't we have one such facility in the community? Well, there are two answers, one is probably more than one is needed in many of these instances. In the State of North Dakota certainly more than one CT scanner was needed and that's been demonstrated.

Second, as I tried to explain earlier, there is competition among providers and a manifestation of that competition is that various providers try to provide low quality of services. That's to the benefit of the consumer in terms of quality and not to the benefit of us all in terms of cost.

Another factor that I don't know whether this is public knowledge or not, but over the past few years when medical providers in this specific community have a discussed possible cooperative in joint ventures and closer relationships in an effort to avoid unnecessary duplication or at least to cooperate on developing certain facilities, we have been very significantly constrained by considerations and antitrust legislation and investigation, and that has been the pertinent factor in Fargo-Moorhead.

Senator CONRAD. I just think that's an important point to have on the record here, that it points here we have Federal government policy sort of the right hand doesn't know what the left hand's doing. On the one hand we want costs restrained. One way to do that would be to have a common set of services. On the other hand, we have another part of the Federal government saying to the institutions who are competitive, if you seek areas in which you don't compete, we might come after you for reducing competition. And so we have some societal judgments that have to be made here. What's going to be—what's going to be the underlying principle that we use to make judgments? Is cost going to assume such an important position that it has to be the overriding consideration or are we going to continue in a situation which you want competition basically unrestrained which pushes obviously in this cost area, pushes cost up.

Let me go next to Dr. Radke, the president of Fargo Clinic, and again I very much appreciate your participation and if you'd summarize your testimony, we'll proceed and then have a chance for further questions.

STATEMENT OF DR. WALLY RADKE, PRESIDENT, FARGO CLINIC

Dr. **Radke**. Thank you, Senator Conrad.

Dr. Knutson I think has outlined very nicely the growth that has occurred, the expansion that has occurred in group practices in this region, in northwestern Minnesota and eastern North Dakota. And our practice is similar in many respects. We have a group practice of 240 physicians at multiple locations throughout this part of the State of North Dakota and Minnesota.

Before I move into my testimony, I would like to just emphasize the point that Dr. Knutson and Senator Conrad concluded with, and that is the issue of the Federal Trade Commission. We do and are constrained and restrained from cooperative efforts in this community particularly, and I think, Senator, that is an issue that you need to be very cognizant of. We are currently involved with an inquiry by the Federal Trade Commission which is looking at that very issue. So I think that from our perspective we would like to be more cooperative in a number of different ventures.

I will not repeat the points that Dr. Knutson has outlined so well. I would like to just share a viewpoint and it's my own perspective having practiced in this area for the last 13 years. We're addressing two major problems, the increasing cost of medical care and the problem of the uninsured. This is a national problem. It's obviously one that does not have an easy solution. I personally do not feel that the current system of health care in this country or in this region is working well. It is working and it is providing a superb medical care for those that can afford it. But I think everyone in this room can relate instances of family members perhaps who cannot afford medical care who cannot afford the medical insurance. So I don't feel personally that the system that we have is currently one which is working. I believe that the system of health care does need to be changed, and I think that we need to be able in this country, in this region to provide at least minimum health care to all of our citizens.

Now, it's inevitable also that the same level of care is going to be given to all, and this is nothing new. For as long as I can remember, there have been people in this region that when they wanted an extra level of care or they wanted another opinion may travel away to the Mayo Clinic or they may travel to another large medical center to get that opinion. They could do that because they can afford to do it. My point is simply that that will likely continue and I don't have any problem with that, but I do believe that we need to provide a minimum level of care, a minimum standard of care for all of our people.

I personally do not think that competition has worked well. Now, some make the argument that if you have a true model of competition, which we do not have, that it will work well. I have some real concerns about that. I think that the competition that I've seen even in this region rarely has decreased costs. I think that the duplication that has been referred to has continued and I doubt very much that having the competitive posture that we've had is going to do anything to reduce medical costs. So I do believe that we need to have a change. I think that it will likely be done on a national level or perhaps on a State level, although, I think the former more likely than the latter.

The questions——

Senator **Conrad**. Can I just stop you on that point because——

Dr. **Radke**. Sure.

Senator **Conrad**. Wouldn't a State approach create very serious problems for us, especially for a State like ours? If North Dakota were to march out, do you remember years ago we had an initiative that was a health based initiative and it concerned me we'd become an island here. We're in no position to be an island. So it would strike me that a State solution, one by one, probably are—might be attractive and we're starting to see that happen, but that there's some real concern about what that would do to our area.

Dr. **Radke**. Yes; I agree with that. And the question then is whether or not consumer expectation will allow that to happen. I think that we can overlook consumer expectation. Consumers do expect good quality care, and that is seen by health providers every single day. If we set a minimum standard of care for those that are uninsured, can we expect transplantation, heart transplantation, kidney transplantation, can we expect the more sophisticated, magnetic resonance imager to be done for those people that have only that minimum standard of care? I think that those are crucial questions that need to be addressed, but I certainly feel that we need to have a program that provides some minimum standard of care for all citizens.

Senator **Conrad**. If it's not to be a State program, I'm taking from your comments this, I'm concluding from them it will be, almost have to be some national initiative, am I correct?

Dr. **Radke**. That's correct. I see the support for that, even the demand for it growing.

Senator **Conrad**. I think all of us have some trepidation. I do. I'm part of the Federal government. Now I watch how we work or sometimes fail to work and it makes me very, very nervous to know that the Federal government is somehow going to wave a wand and going to decree how the health care system is going to work. Is that really the only alternative that we have? Is there no way that we can have some public private partnership in which we keep a very strong component of private sector initiative in this process? You know what I'm saying?

Dr. **Radke**. Sure.

Senator **Conrad**. I'm very worried about the Federal government coming in and saying this is the way it's going to be done in Fargo, and this is the way it's going to be done in New York, two different environments and two perhaps very different solutions are called for and you get one.

Dr. **Radke**. I think your points are very well-taken. I think the idea would be to have some sort of combination. It makes everyone nervous to think that the government is going to be the one that has the solution for us. I don't think that we have the alternatives in mind yet or drawn to tell us what that may be.

Senator **Conrad**. Let me ask you it this way. Is there any way realistically that a solution can come from the private sector? I mean given the diversity, given the competitive position they're in, given the threats of FTC action, all of those factors, is there any way that doctors, hospitals, clinics can come together nationally and come forward with some solution? Is that just out of the realm of point?

Dr. **Radke**. Well, I would love to say that that's the way it should be done. I would like to see it done that way, but realistically speaking, I'm not sure that that can be done. Certainly if it can be encouraged by the Federal government and if we can see a movement in that direction, I think that then that is probably the most appropriate and the best way to do it. But as of this date I don't think we have any well-defined alternatives.

Senator **Conrad**. All right. Thank you very much. Next we'll hear from Mr. Larry Narum, president of St. John's and St. Ansgar Hospitals.

STATEMENT OF LARRY NARUM, PRESIDENT, ST. JOHN'S/ANSGAR HOSPITAL

Mr. **Narum**. Thank you, Senator.

As I was writing some notes down as I was thinking, a lot of those points have been covered, but let me just give you sort of a general rather than a hospital specific and maybe we can go back to some of those questions you asked before.

I think one of the problems we've got with the health care delivery system, it is the conflict between expectations and reality. I think about some of the programs we put out. One of the case studies I did in graduate school was to go back and look at the beginning of the Medicare Program. If you go back and you dig into the details, it's real interesting that we sort of set ourselves up for saying to all of the elderly in the United States, this program is going to take care of your health care costs and don't worry about it. And we did sort of the same thing under Medicaid, but I think the reality says that's not working.

What we have to do is go back and sort of ask ourselves why. What are we spending those $500 billion on, and what are we getting for the $500 billion that we're spending, and what kind of care can we and should we provide I think are the most important questions. I think a lot of the questions that you're asking will come out of those discussions. Discussions have never been held because it's a real uncomfortable kind of a discussion. If you look at the statistics, a lot of money spent by the Medicare Program is spent in the last 6 months of a person's life. If you look at the last 30 days, I don't remember what the statistics are, but it's 20 to 30 percent of the dollars are spent in the last 30 days of a person's life which says that the health care field is doing a lot of very expensive heroic, if you will, kinds of things in the last few days of people's lives. Is that where we want to spend our money? That's the sort of discussion that I think——

Senator CONRAD. Can I just intercede there? Who makes the decision in the current medical community complex of decision makers where you have hospital administrators, you have the doctors who are providing directly the care, who makes the decision about how you treat that patient, what the policy is? The individual doctor determines what's appropriate or how is it determined what the policy is for how we intercede in the last 30 days, for example?

Mr. NARUM. Well, it's usually a combination—a discussion between the patient if the patient is competent to make that decision, family and physician and the hospital sort of a group decision made.

Senator CONRAD. The hospital administrators—they give certain guidelines to physicians, primary care physicians on how to proceed in that circumstance or not?

Mr. NARUM. No; we have some policies we've set up citywide that do not resuscitate those sorts of policies. We have all sort of agreed that if the patient decides not to be resuscitated no matter which institution, nursing home, hospital, emergency room, ambulance will all abide by those sorts of rules. But no, there are no hard and fast rules because it's really a decision that has to be made by those——

Senator CONRAD. By the family?

Mr. NARUM. Family, for both moral and legal reasons have to be that sort of a decision made. But that's the kind of—you know, we're spending lots of money, and the question is, what are we getting for the money we're spending, I think is the real important issue. I think we have to have that discussion before we can get a lot farther down this road because the solutions we had up to this point in time are really sort of trying to get at the symptom, I think, rather than the problems.

The DRG's were a step in the right direction a lot of people think, but then when you realize that we've identified DRG's in the hospital where there is excess revenue over costs. We've identified DRG's in hospitals where there is not sufficient revenue to cover the costs. The ones where there are access revenues is being tightened down, where the ones in the bottom are being loosened up.

So you think about revenues from medicare being used to offset care for the poor, you think about revenues from insurance companies being offset to take care of the poor. You know, everybody wants to say pay at the level where they're providing the service for their own employees or their own people. The dollars left over to provide care for the poor are getting to be smaller and smaller. As they get to be smaller and smaller, prices go up because there are a fewer number people that you can spread those dollars over which just sort of forces the insurance up which forces more employers up. It's just a vicious cycle. I'm not sure how we get out of, but I think one of the first steps is to look to see where we're spending our money.

One of the classic areas I think are the difference between the urban and the rural payments under medicare. Again I don't quote my statistics, but my recollection is that in the medicare funds 5 percent are spent in the rural areas. It really makes sense to make all those rural hospitals go through all that paperwork for that or should we just sort of let them do their thing and spend their money? I think we need to look at other revenue sources to help pay for the health care of the country. This is where my sort of radical side comes off.

We know what causes people to get sick. Smoking causes people to get sick, driving too fast causes people to end up in the hospitals. Those are all sorts of areas where we haven't taken the dollars from those areas and plunked them into the medicare funds, if you will, or the medicaid funds to help pay for it. So we're all sort of paying for some of the things that we know if people didn't know they wouldn't get guite so sick.

So I think the question of what are we spending our dollars on, is that what we want to spend our dollars on, and are we getting the most for it, is the first question that has to be answered before the rest of it. Then I think once that question's answered, and I heard what you said earlier, that's a real uncomfortable kind of endeavor, but I think that's the question that's been avoided all along.

Senator CONRAD. You know, I've reached a conclusion that these are comfortable conversations to have. It's never comfortable to go look at somebody else's business, but really that's where we're at. You know, we've got a system that's in very, very serious jeopardy, and somehow we're all going to have to sit down and talk very honestly and openly to each other about how we address these things or the likelihood is we'll have some solution interposed upon us, and almost always those are worse.

Mr. NARUM. I agree with you. It's got to be an open dialogue because one of the things, there has to be a realistic reimbursement for the services that we're providing. In some cases there is, some cases there isn't. I think we both have to be honest with each other. The health care industry hasn't done everything it can to keep costs down, but part of the problem is some of the ways some of these reimbursement issues are designed. They're counterproductive to doing things in a cost-effective way.

When you get under—medicare is the biggest purchaser of health care in the country, so they sort of set the trend. It's sort of like you sit down and figure out what the rules of the game are and you figure out how you maximize that so when you're on the other side, you understand very well how to do that. And a lot of times it makes no sense some of the things we have to do to get dollars back from the medicare. That's part of what we're spending our dollars for.

I think the other wall that we're sort of up against now is that since we have concluded, I think we have concluded that there are only finite dollars that we can spend on this particular problem. The well is running dry. Anytime you run into finite dollars, you can expect only so many dollars in an increasing demand sort of a situation. You start to have allocation or rational to get those dollars and that's what I think if we don't solve the problem. And that's going to be a real uncomfortable situation because I know health care providers aren't going to be the rationers of those dollars, so probably takes us back to the government.

Senator **Conrad**. That really is what it gets down to. I mean at some point there has to be a public policy decision made and in democracy ultimately the elected representatives get to make that decision, and that's a very sobering, very sobering thing to have to face.

Let me just go next to Gary Rudolph, the vice president for finance of St. Luke's Hospital. Gary.

STATEMENT OF GARY C. RUDOLPH, VICE PRESIDENT FOR FINANCE, ST. LUKE'S HOSPITAL

Mr. **Rudolph**. Thank you. thank you very much for allowing us to come and give some testimony here. I think sometimes when we come to these hearings, they could almost be better served as debates. As I sat out in the audience I heard a number of issues brought up that I really wasn't going to elude to, but I think it's necessary to bring out the actual facts and situation.

We heard that an MRI was available through the VA. That isn't true. There was no MRI available to the VA, and the VA is very low-funded through the Federal government and the Federal government wasn't about to put a million dollars into the VA for an MRI.

The MRI at St. Luke's is shared with an MRI in Grand Forks. It's a mobile MRI. It goes from Fargo up to Grand Forks. That's done so that full extent utilization can be obtained through that MRI. It doesn't just sit at one facility. It's fully utilized between two facilities.

Competition, we're told that we're not competitive, yet criticized if we have marketing costs and advertising costs. We are competitive, and feel that a free market is important for everybody here to get the benefit of price competition.

We heard that the air ambulance is referred to as a bell and whistle. Well, I'll tell you, for individuals that I've seen that their life has been saved through an air ambulance. It's not a bell and whistle. It's a life-saving necessity.

So we've got a question, what do we need? Yes, health care costs are high. And I would say one thing, one point that's really important. Every hospital in North Dakota is a nonprofit entity, and as a nonprofit entity, our mission is to care for every person that's in North Dakota that needs care. In other words, we cannot—we do not and regulationally-wise, we cannot turn anybody away for care. So our mission is to provide a lot of free care.

Now, I do have some charts I want to share with you, and I'll try to be as quick as I can. One of the things we've got to really identify is when we're talking about health care costs, what are we talking about? We're talking about what it costs you as beneficiaries to get health care, what you pay. In other words, what the hospitals and health care entities charge you, not what it costs the individual entity. We have costs also as organizations. We have employees that have to be paid, we have supplies that have to be bought, we have malpractice insurance that has to be purchased, we have buildings that depreciate and have to be rebuilt, so we have costs also.

This chart here will show you what has happened nationally in health care costs. The higher amounts there from 1988 to 1989, you see in 1988 health care costs went up by about 2.3 percent, this is nationally. 4.2 percent in 1987. In 1988 4.7 percent, and 1989 5.4 percent.

Now 50 percent of our patients are paid by the Federal government. In other words, 50 percent of the patients that enter our doors, our only reimbursement for their care is through the Federal government or from the State government, medicare and medicaid.

Now, you can see there nationally what's happened, is nationally the rates have gone up. But take when rates have gone up 3.3 percent, the rates have gone up that went up for the individual perspective payment rate or the amount that the government pays for those patients went up by ½ percent. And across, you can see the line there, going up marginally in relationship to what the cost is. Again, this is a national amount.

Now, I'd like to share with you some hospital specific amounts for St. Luke's Hospitals, and I'm sure it's the same for other entities. I hope you can see this chart. The dotted line going straight across, that shows how much from 1985 to 1989, we've established 1989, payments per case have gone up coming to our facility. In other words, in 1985 the Federal government was paying just over $5,000, in 1985.

Senator CONRAD. It that per patient?

Mr. RUDOLPH. Yes; that's on a per admission basis.

In 1989 that amount is right at about $5500. We're talking abut 5 years.

Now, our costs have gone up. We have to pay individuals, we have to pay people. The cost of health care to health care entities is important. We're one of the largest employers in this State, so we're concerned about health care costs also.

Now, when we talk about uncompensated care, and the statements been made that the larger facilities are not as involved in uncompensated care. This line will show you what uncompensated care has been, what patients coming in our doors do not pay. In 1984 going to 1988 you can see a rise. And that rise in 1986 going to 1988 has increased substantially because what's happening is the Federal government for medicare and medicaid patients pays us a percentage of our revenue and that revenue, that percentage is dropping far below costs.

Now, we heard the statement that this situation of less reimbursement to individuals, we heard the statement. That this is a legitimate frustration. I would say that it's the entire problem that we're having. It's not just a legitimate frustration.

CRISIS IN RURAL HEALTHCARE: HEALTHCARE COSTS AND THE PROBLEMS OF THE UNINSURED

U.S. SENATE BUDGET COMMITTEE HEARING

FEBRUARY 13, 1989 FARGO, NORTH DAKOTA

TESTIMONY OF

GARY C. RUDOLPH

VICE PRESIDENT OF FINANCE

ST. LUKE'S HOSPITALS--MERITCARE

According to a recent survey done on behalf of the North Dakota Hospital Association, the rising cost is the number one healthcare concern of North Dakotans. The hospitals in this state and around the country are concerned about this problem too. St. Luke's Hospitals--MeritCare takes this issue very seriously, as it effects us as the largest healthcare provider in the state and as one of the largest private employers in North Dakota. Each employee of our organization works everyday to insure that our patients receive the best quality care in the most cost efficient manner. Fiscal responsibility is a very important part of our work life, from the President of our hospital to each nurse on the floor caring for our patients. But despite our efforts and the efforts of many hospitals around the country, healthcare costs continue to rise, and consumers and employers see their insurance costs and copayments increasing drastically. Why has the cost of healthcare to the average consumer increased faster than the general rate of inflation? There are several factors which have contributed and are not under the control of healthcare providers:

1) The cost of goods and services purchased by the hospitals has increased at a faster rate than general inflation.

The price of the market basket of goods and services we need to purchase in order to provide our patients with medical services has increased faster than the Consumer Price Index. The CPI has increased 9.9% over the past three years while the cost of goods and services purchased by hospitals has risen by 12.2%. The shortage of healthcare personnel, especially nurses, has increased labor costs as hospitals, nursing homes and other providers compete for the dwindling pool of qualified professionals. The cost of supplies has increased as the hospitals have implemented new procedures to protect their employees from contracting contagious diseases such as hepatitis and AIDS. Liability insurance premiums have skyrocketed. The introduction of costly new technologies continues relentlessly. These are but a few examples of factors which have been pushing up the cost of providing healthcare to our patients, and which are beyond the control of hospitals.

2) On the other side of the equation, government payments to hospitals have not kept pace with the cost to treating patients.

The increases in reimbursement on a case by case basis (PPS) has increased at less than half the rate of cost increases. In addition, the government has decreased the reimbursement for capital expenses, resulting in a widening gap between the cost of treating patients covered under government insurance programs and what the government pays the hospital. The government is simply not paying their fair share of the costs of healthcare services.

In the case of St. Luke's Hospitals--MeritCare, for the average Medicare patient in fiscal year 1988, there was a gap of $1000 per patient between the cost of care and the reimbursement from the Federal government. This resulted in a $4.48 million dollar loss in the last fiscal year from treating Medicare patients.

St. Luke's total uncompensated care for Medicare, Medicaid, and uninsured patients has increased more than 150% in the past 5 years, from $6.0 million in FY 1984 to $15.4 million in fiscal year 1988. That is nearly 18% of our total patient revenue in 1988. In fiscal year 1989, this figure is expected to reach nearly $20 million at St. Luke's Hospitals.

In order to compensate for this loss, hospitals have been forced to increase prices more dramatically for those covered under private insurance programs. The increase in charges at St. Luke's, for example, would have been much more moderate if government payments had kept up with the hospital market basket. You can see that in 1988, St. Luke's Hospitals--MeritCare increased charges by 8%, though if the government had provided adequate payments, the increase would have been only about 1/3 of that amount.

RESULT

The result: a continuing deterioration in the financial condition of the hospitals in the United States and in rural areas in particular. Net patient revenues have declined steadily since 1984 to 0% in 1988 and are projected to be negative in 1989 as hospitals find it harder to shift costs to other payers, cost which should be borne by the government. Hospital closings hit an all time high last year (80 hospitals closed their doors). If something is not done to restore adequacy, equity and predictability to the PPS system, there may even be an erosion in the quality of care.

RECOMMENDATION

I ask you to fight for full funding of the Medicare program via the FY1990 budget resolution, to provide for a standardized update based on the true cost of providing care to patients, as measured by the hospital market basket, and to provide for a severity of illness adjustment to ensure that hospitals are reimbursed for the amount of resources required to treat their patients.

Senator CONRAD. Well, I think you may have said it right. Maybe we'd be well-off to have a bit of a debate because I think you've raised an issue which leads me to want to conterargue for the purposes of trying to illuminate where we are.

You make the point that the problem is the Federal government not paying its share. Let me just review for you what's happened from the Federal government perspective in terms of the medicare budget. In 1987, $84 billion and in 1988, $94 billion, so more than a 10 percent increase. In 1989 $107.5 billion.

The Reagan proposal—these are budget authority numbers now. The Reagan proposal for fiscal 1990, $125 billion. So it is true that if you look at what it would take to provide the same level of services for 1990 as you provided in 1989, the Reagan budget is $5 billion less than needed to provide the same level of services. But if you look at it from the perspective of just exploding costs, we're going form $107 billion to $125 billion in budget authority. This at the time, the Federal government is nowhere close to paying its own bills. I mean, you know, you want to look at something that's out of control.

We say we're reducing the Federal budget deficit. Does anybody remember when we had that big Summit agreement 2 years ago and they said they're going to reduce the Federal budget deficit $70 billion over the next 2 years, does anybody remember what the Federal budget deficit was 2 years ago? $155 billion dollars, $155 billion 2 years ago. Anybody know what it's going to be this year? $170 billion. Do you see any $70 billion reduction? It hasn't happened. And yet you have the entire leadership of this country go and attempt the President of the United States, the Republican leaders of Congress, the democratic leaders of Congress and they said they came out with a plan that was reducing the deficit $70 billion over the next 2 years and it's gone up 15. It doesn't end there because the real story is much worse. The real story is the increase from $155 to $170 isn't the true increase because we've been taking the offset of the Social Security surplus. Back then the Social Security surplus was $39 billion for the year. This year, $68 billion.

And so what appears to be the deficit from what really is the deficit are two very different things. And, you know, if you look at it from the perspective of the Budget Committee and we say the problem is the Federal government's not keeping its share, I can understand from the perspective of the hospital that sees the increasing costs and the Federal government not be able to trace those costs, that you make that statement.

But from the perspective of the Federal government and the budgeting for the Federal government, you look at these enormous increases in what the Federal government's done, we've gone from $84 billion in 1987 to $125 billion in this year, so in the 3 years almost a 50 percent increase, 3, 4 years. That strikes me that the problem, the real underlying problem, I don't diminish for a minute that if you're sitting in, the perspective of provider, the problem there is Federal government's not covering its share, but if you back up and take the broader view, I think it's almost inescapable that this cost escalation is going to beggar all of us.

Mr. **Rudolph**. I think if you use it in aggregate, to bring aggregate numbers in you're absolutely correct. But the number of people that have gone on the roles of medicare and medicaid have almost doubled over that peroiod of time. So automatically if you're going to be an insurance company that's going to insure 50 percent more people, it's going to cost you 50 percent more money; and that's one thing that I have no question, and I don't think anybody would debate this, that we have a situation where the cost the government is paying is astronomical. Can we afford to keep it up?

The concern I have is if we tell people they have coverge and we are acting as an insurance company and the Federal government is, in fact, acting as an insurance company, that coverage should be there.

I'll give you an example. The most recent coverage for catastrophic health care that was—it was a number of individuals thought it as a fantastic program for coverage. That coverage will actually result in less coverage or less payment to the hospital. The reason for that is payment is based on a fixed sum, a DRG rating regardless of how long you're in the hospital. Prior to the catastrophic health bill, many people had private coverage for after they weren't covered by medicare, now many people have dropped that coverage because they feel they're covered under the catastrophic health care bill, in fact, they are. But for that care that they're provided, they will not, the hospitals will not receive one dime more. That's basically what I'm talking about when I say that the government is not paying its share. The government is paying a huge amount in aggregate, but the government has an awful lot of beneficiaries for which I don't know if they can afford the bill for them all.

Senator **Conrad**. OK. Very good. I want to thank the first four members very much. You've been terrific, and we appreciate your participation.

Next we're going to hear from Jim Austin, the director of administrative affairs for Blue Cross-Blue Shield and then we'll hear from D.D. Wightman, the president of Dakota Hospital in Fargo, and then Dr. Justes Fiechtner of Dakota Clinic. Gentlemen, welcome.

STATEMENT OF JAMES A. AUSTIN, DIRECTOR, ADMINISTRATIVE AFFAIRS, BLUE CROSS-BLUE SHIELD OF NORTH DAKOTA

Mr. **Austin**. Thank you very much. Since you received that slip, I have been promoted, so I'm no longer director of administrative affairs. I'm vice president of community relations of Blue Cross-Blue Shield of North Dakota.

Senator **Conrad**. Does that mean that you got a pay increase, Jim?

Mr. **Austin**. No.

Senator **Conrad**. I just want you to know, we in Congress didn't get a pay increase either. Let the record show that.

Mr. **Austin**. That was very difficult, I'm sure, Senator.

Senator **Conrad**. Thanks, Jim. We've heard enough from you.

Mr. **Austin**. On behalf of our company, I would like to thank you for allowing us to present testimony at today's hearing. I have a rather lengthy piece of testimony that I would like to submit as part of the record, and I will summarize if that is allowable.

In recent years third-party health care coverage costs have experienced sharp increases. These increases are driven not only by the cost of health care services, but by how much those services are used. Both the cost and use of services have increased tremendously for a number of reasons. The following are included: Rising consumer expectations and demands for services, government programs, as was pointed out earlier, and changing demographics.

In North Dakota, for instance, we have approximately 106,000 people in our State who are on medicare. We anticipate that that figure will grow by 4 percent per year over the next 10 years, so we do have an aging population in North Dakota. And as I think you will agree, Senator, as the population gets older, the number of services increases.

You have already discussed the speculation that hospital costs will triple in the next 12 years or 11 years to the year 2000. If I could, I would like to review with you briefly the hospital costs that we have experienced here in North Dakota. Back in 1955 a day in the hospital cost about $20.25 here in North Dakota.

Senator CONRAD. What year?

Mr. AUSTIN. 1955. Jumping to 1978, the cost for an average day—for a day in a North Dakota hospital averaged $117.12. We have just completed our research on 1988 and the cost for an average day in a North Dakota hospital in 1988 was $675.

What this has prompted Blue Cross-Blue Shield of North Dakota as well as other health care insurers to do is get involved with what we call a manage care program, attempt to control the utilization of medical services. The manage care program includes such things as preadmission authorizations, concurrent review and the like. Again, the details of those programs are contained in my testimony and I will not get into them right now.

In the area of payments to hospitals, and hospitals is one of the most expensive areas when it comes to health care. Since 1986 we have been working to bring about a prospective type payment program for hospitals. We currently have in effect 12 per diem payment contracts and one DRG contract with the largest hospitals in North Dakota. Payments are adjusted annually based on the medical component of the consumer price index. We recently filed a new contract with the insurance department providing for a discount from the hospitals in which further puts a limit on the amount of profit the hospitals can earn on our members.

I would draw your attention to the following, however, Senator. There is a downside risk in our attempts to hold down hospital costs. All 51 hospitals in North Dakota have a board setting their hospital rates at the level necessary to maintain operations. No hospital in North Dakota is making big money. In fact, reports show over half lost money last year. With medicare not paying the cost of providing services to the elderly, with the State of North Dakota not paying the cost or providing services to the medicaid population, and with the Workers' Compensation board proposing legislation and the North Dakota legislature to likewise, we will be very surprised if we're going to see hospitals continuing in places such as Park River, Ashley, Bowman, Crosby, New Rockford and the like, particularly if we attempt to get the same type of discounts from these hospitals.

Finally, Senator, I would like to discuss with you briefly the problem of the uninsured here in North Dakota. In a program that has been started by Blue Cross-Blue Shield to take care of the children in our State who are uninsured, about 2 years ago we began a study to try to determine how many children in our State did not qualify for any type of medicaid or social health, but yet whose parents were at an income level that would prevent them from purchasing health insurance. Working with the North Dakota Health Department, we estimate that there are about 15 to 20,000 of these children in our State.

What we started in North Dakota on January the 1st of 1989 is unique in our area. We began providing health care services to these children through a program that's called the Caring Foundation of North Dakota. There are about 127 children today who have received their first physical since birth that on December 31, 1988 did not have health insurance. I'm happy to say that we have enough money in the Caring Foundation to provide insurance for approximately another 50 children and we are soliciting throughout the State through the social service offices to refer those people to us as they are denied coverage by medicaid. Now, this program would not have been possible in North Dakota if it had not been for the cooperation of North Dakota's providers have who have agreed to accept as payment in full for these children 50 percent what have they normally receive. The cost per child per month to the Caring Foundation is $17.60.

And finally, I would like to add that due to the fact that the 90 percent of these children have not seen a doctor since birth, we insist that within the first 30 days of coverage, those children go to a doctor and have a complete physical. And obviously what we're looking for are some problems that currently may not be a problem, a serious problem but that could develop into one. So we're very excited about the program here in North Dakota and look forward to its expansion.

Thank you very much.

Senator CONRAD. Thank you, Jim.

[The prepared statement of Mr. Austin follows:]

TESTIMONY OF
BLUE CROSS BLUE SHIELD OF NORTH DAKOTA
ON HEALTH CARE COSTS
AND
THE UNINSURED POPULATION

Prepared for the Senate Budget Committee

February 1989

Mr. Chairman, my name is James A. Austin, and I am vice president of Community Relations for Blue Cross Blue Shield of North Dakota. On behalf of our company, I want to thank you for allowing us to present testimony at today's hearing. The testimony will focus on our corporate response to the increasing cost of health care. In addition, we will discuss our approach to the increasing national problem of the uninsured - specifically as it affects our children.

Mayo Christianson, president of Blue Cross Blue Shield of North Dakota, is unable to be here today but wishes to express his appreciation for the Senate Budget Committee's holding field hearings on important medical issues.

HEALTH CARE COSTS

In recent years, third party health care coverage costs have experienced sharp increases. These increases are driven not only by the cost of health care services but by how much those services are used. Both the cost and use of services have increased tremendously for a number of reasons which include:

- Rising consumer expectations and demands for services,
- Government programs, and
- Changing demographics.

NATIONAL AND STATEWIDE STATISTICS ON HEALTH CARE SPENDING

National statistics indicate Americans spend more of their income on health care than the people of any other country. In the past 30 years, public and private health care costs have increased nearly threefold - rising from 4.7 percent of the GNP in 1957 to 11.1 percent of the GNP in 1988. Per capita health care expenditures increased between 1966 and 1986 from

$207 to $1,837, an increase of nearly 900 percent. It is projected by the year 2000 health care costs will escalate to $1.5 trillion or 15 percent of the GNP which translates into a liability of $5,500 for every man, woman and child in our country.

On the state level, health care costs have increased drastically in keeping with national norms. Historical data indicates hospital costs in 1955 averaged $20 per day compared to $675 per day in 1988. Even though programs have been implemented to attempt to contain costs and statewide utilization statistics reflect a decrease in length of stay, overall charges continue to rise. (See Attachments A - H for further information.)

GOVERNMENT INVOLVEMENT

In 1965, the federal government enacted legislation to provide health care insurance for eligible citizens - mainly elderly and disabled individuals. This legislation is commonly known as Medicare and Medicaid. Reimbursement for the cost of health care prior to 1983 was an openended, retrospective, cost-based system of reimbursement which permitted hospitals to collect whatever they charged and encouraged increases in hospital cost of 13 to 20 percent per year. These costs were being borne by both private and public payers. Proactive measures to curb this spending curve were taken by government officials which evolved in the establishment of a prospective payment system better known as Diagnostic Related Groups or DRGs.

The DRG system was directed at containing the goverment's liability, with reimbursement levels being established based on geographic, demographic, and rural versus urban factors.

This increase in operating costs is passed along to consumers and third party payers (like Blue Cross Blue Shield of North Dakota) in the form of higher fees for service. In addition, fear of lawsuits provides incentives for physicians to practice "defensive medicine" by corroborating their judgment through more x-ray and laboratory tests than used in the past. Lastly, the 20th century has promoted the advancement of medical care services. High tech services developed to control or alleviate illness and disease which previously caused death are now available to the health care community - but at a significant cost. This price tag is supported, in part, by third party payers such as Blue Cross Blue Shield of North Dakota.

BLUE CROSS BLUE SHIELD EFFORTS TO CONTAIN HEALTH CARE COSTS IN NORTH DAKOTA

The cost of health care is an issue of great concern to Blue Cross Blue Shield of North Dakota. Although a major driving force among third party payers is to provide access to quality care, there is a responsibility to ensure that unrestricted access does not produce or promote an unwise use of services or unawareness of the costs involved. It is this aspect of the third party system that has caused the Plan to develop a variety of cost containment programs directed at reducing of unnecessary costs and providing incentives to members for the use of the most cost effective services and settings. The benefits of the interrelated programs which Blue Cross Blue Shield of North Dakota has developed to control cost in this area far outweigh the expense of their implementation and administration. These cost containment programs include:

PROVIDER CONTRACTING: Blue Cross Blue Shield of North Dakota contracts with 100 percent of North Dakota hospitals and approximately 99 percent of North

Dakota practicing physicians. Because participating hospitals, physicians and other providers are assured timely payment for necessary services, bad debts and payment collection problems are reduced and cash flow and financial management are improved. These arrangements, along with other contractual provisions, enable the Plan to purchase health care services at negotiated rates which translate into price reductions. In 1987 these negotiated rates with hospitals amounted to approximately $1.5 million in savings.

USUAL, CUSTOMARY AND REASONABLE: Another approach to price reduction used by the Plan is the usual, customary and reasonable (UCR) fee reimbursement method. Under UCR, Blue Cross Blue Shield of North Dakota pays a physician's full charge only if it does not exceed his usual charge, if it does not exceed the amount customarily charged for the service by other physicians in the area or it is otherwise reasonable. Both the usual and customary amounts are based on the most common fee charges over a period of time by a group of physicians. By reimbursing physicians according to this calculated payment, the Plan is able to slow increases in amounts paid out in claims which in turn is reflected in controlling membership fees and premiums paid by Blue Cross Blue Shield of North Dakota subscribers.

As an additional benefit to subscribers, participating physicians have agreed to accept the UCR amount as payment-in-full. That is, the physician will not bill the patient for any difference between his original fee and the amount Blue Cross Blue Shield of North Dakota has paid. This program, known as "service benefits," is important to our subscribers because it makes the price of care predictable and removes the worry about out-of-pocket expenses. Savings during 1987 approximated $9.7 million

OTHER PARTY LIABILITY (OPL): Blue Cross Blue Shield of North Dakota has implemented four major Other Party Liability programs to handle claims that are covered by more than one insurer so that a subscriber receives all the benefits he/she is entitled to, but not more. These OPL programs, through their individual methods of decreasing the number of duplicate payments, represent significant dollar savings for the Plan which ultimately reduces out-of-pocket costs for our subscribers.

1. **Coordination of Benefits or COB** detects the presence of more than one source of coverage and assigns the liability for each claim to the appropriate coverage. The result is to ensure that each carrier is only paying the amount for which they are liable. COB savings for 1987 approximated $2.8 million.

2. **Subrogation** is a legal process through which the Plan recovers payments from a subscriber whose personal injuries are caused by another party's negligence. It is a very useful program for assigning health care costs to the responsible party, and it has the effect of reducing the rate of increase in premiums. Subrogation savings approximated $118,000 in 1987.

3. **No-Fault Program** provides fair settlement to all persons sustaining bodily injuries as a result of an automobile accident without regard to which party is at fault. Under North Dakota law, an eligible subscriber injured in an automobile accident is required to collect the first $5,000 of benefits from the no-fault (i.e., auto) insurer prior to making claims on Blue Cross Blue Shield of North Dakota. Savings from the program approximated $504,000 in 1987.

4. **Workers' Compensation Program** identifies claims for injuries which have arisen during the course of employment. By screening claims, Blue Cross Blue Shield of North Dakota is able to detect work-related injuries and take appropriate action. These claims are eligible for benefits under the North Dakota Workers' Compensation program. Savings approximated $717,000 in 1987.

BENEFITS MANAGEMENT PROGRAM The Benefits Management Program consists of two areas which assist in the establishment of sound medical policy to guide payment for provider services to control medically unnecessary procedures and tests. These two areas are the Medical Review Unit and the Utilization Review Unit.

The **Medical Review Unit** evaluates clinical practice and medical technology to determine which practices and tests are outmoded, of unproved effectiveness, or appropriate only in specific circumstances, the end result of which is to reduce unwarranted utilization. The unit consists of four review levels with active participation from Blue Cross Blue Shield of North Dakota's medical director and Medical Review Committee. Savings in 1987 approximated $564,000.

Working in cooperation with the Medical Review Unit is the **Utilization Review (UR) Unit.** The UR unit contributes to the containment of costs by making sure the services rendered were medically necessary and provided at the appropriate level of care to the extent that actual claims are denied due to inapprorpriate hospitalization. Savings associated with UR in 1987 approximated $2.1 million.

MANAGED CARE PROGRAM - WHAT IS IT? - COMPONENTS. **Pre-Admission Authorization** is a major component of the Managed Care Program at Blue Cross

Blue Shield of North Dakota. The program requires the subscriber/physician to notify the Plan for pre-authorization before non-emergency hospital admissions. Emergency and maternity admissions require notification within 24 hours after admission for a length of stay assignment. By requiring Pre-Admission Authorization, Blue Cross Blue Shield of North Dakota hopes to accomplish three cost containment goals: 1) immediate savings of the differences between the cost of outpatient vs. inpatient care; 2) long range savings through the reduced need for additional hospital beds; and 3) the determination of appropriate length of stays.

Individual Benefits Management Program. Another major component of the Managed Care Program is Individual Benefits Management. This component is an organized effort to identify high cost patients as early as possible (i.e., those individuals who have experienced catastrophic accidents or illness), access alternative treatment methods and manage health care benefits for these patients as cost effectively as possible even if it means providing benefits which normally would not be available. There is growing recognition that better management of the cost of care for these patients may produce significant savings for consumers of health services as well as increased social benefits for individual patients and society.

INNOVATIVE BENEFITS. Blue Cross Blue Shield of North Dakota has developed a number of innovative benefit programs designed to reduce health care costs by encouraging the delivery of services in a less expensive setting than traditional hospital care. A few such innovative benefits include: same day surgery, pre-admission testing, second opinion surgery, and home health care and preventive services.

QUALITY CONTROL AND ASSESSMENT. The Quality Control and Assessment function consists of three areas which are responsible for an increase in quality benefits as well as improved productivity and customer service: 1) the quality assurance (QA) function monitors and places controls on the processing of claims; 2) the fraud and abuse program detects, investigates and prevents program mis-utilization, abuse and fraud; and 3) Blue Cross Blue Shield of North Dakota also is involved in the substantiation of delivery of services, appropriateness and proper ordering of services as well as accuracy in costing and pricing. By performing this function, Blue Cross Blue Shield of North Dakota is able to confirm the validity of payments to Providers.

NORTH DAKOTA'S UNINSURED

In recent years, the media has drawn public attention to the plight of the uninsured in America – a segment of the population which unfortunately is expanding at a rapid pace. Surveys conducted show that between the years 1980 - 1987 this segment increased by 25 percent.

Nationally, it is estimated that 38 million Americans under the age of 65 had no private or public health insurance or public health expense coverage. This number represented 18 percent of Americans under the age of 65 - 15 percent of the total U.S. population.

Of these uninsured individuals, 30 percent or 12 million are children under the age of 18. It is reported that nearly 20 percent of American children have no insurance coverage.

Sadly, the national percentages regarding children are reflected in our own state. According to the state's Department of Human Services, 20,000 children in North Dakota are currently not covered by any form of health insurance - public or private. These children are known as the "gray children." That is, they are members of families whose annual income levels exceed the Medical Assistance guidelines but still fall below the federal poverty level making it financially impossible for their parents or guardians to afford health coverage.

These "gray" children have not been overlooked. In 1987 Blue Cross Blue Shield of North Dakota made a corporate commitment to develop a community service program specifically designed for the "gray" children of North Dakota who have been deprived of access to required preventive and primary care.

Through a cooperative effort with health care providers statewide, these children will now receive the care necessary to keep them "healthy." Blue Cross Blue Shield of North Dakota participating health care providers have agreed to accept substantial reductions in their reimbursement for services rendered to Caring Program enrollees.

Health care services ranging from preventive checkups and immunizations to surgical services benefits will be covered under the program. The fragmentation of health care services provided to these children will be eliminated through the establishment of treatment plans. A tax exempt foundation has been established for the funding necessary to support this much needed children's health care program.

The program has been very well received on local, state, and national levels, attaining recognition and endorsements from organizations and associations as well as individuals.

As a concerned parent has written:

"Dear Caring Foundation,

> "Here is an application for my daughter, Alexandra Jade Tweten. She would sleep much better if she had insurance. She is round and sound and doesn't anticipate needing any, but you never know...she could be chasing after snowflakes...and run into a tree...or be dancing in the livingroom and slip in her jammys...any number of things could happen and she could bump her precious little head. We just love her so much and we can't afford insurance."

Thank you for the opportunity to present information on behalf of Blue Cross Blue Shield of North Dakota on the issues of increasing health care costs and the uninsured.

We appreciate your interest in these issues and support your continued efforts in seeking out innovative solutions to these complex problems.

ATTACHMENT A

Statewide Urban/Rural Comparison
Claims Incurred 01/01/85 - 12/31/87

CLAIMS INCURRED AT URBAN HOSPITALS

	1985 Urban Claims	1986 Urban Claims	Percent Change (85-86)	1987 Urban Claims	Percent Change (86-87)	Percent Change (85-87)	1985 Urban Days	1986 Urban Days	Percent Change (85-86)	1987 Urban Days	Percent Change (86-87)	Percent Change (85-87)	1985 Urban Charges	1986 Urban Charges	Percent Change (85-86)	1987 Urban Charges	Percent Change (86-87)	Percent Chang (86-87
PATIENT -																		
dical	4,458	4,293	-4.5%	4,129	-3.8%	-8.2%	21,984	22,185	1.0%	21,335	-3.8%	-2.9%	$ 12,223,446	$ 13,631,453	11.5%	$ 14,952,483	9.7%	22.
ternity	2,502	2,364	-5.5%	2,198	-7.1%	-12.2%	8,522	8,130	-4.6%	7,066	-13.1%	-17.1%	7,648,536	7,776,050	1.7%	7,910,920	1.7%	3.
rgical	5,138	5,129	-0.2%	4,840	-5.6%	-5.8%	28,811	28,903	0.3%	27,024	-6.5%	-6.2%	21,733,990	25,479,574	17.2%	25,748,519	1.1%	18.
ych	572	494	-13.6%	450	-8.9%	-21.3%	7,740	6,799	-12.2%	5,803	-14.6%	-25.1%	2,309,115	2,407,729	4.3%	2,204,756	-8.4%	-4.
om Dep	572	525	-8.2%	577	9.9%	0.9%	13,722	12,875	-6.2%	13,413	4.2%	-2.3%	2,084,955	2,203,309	5.7%	2,384,984	8.2%	14.
jects	403	475	17.9%	669	40.8%	66.0%							916,991	1,015,206	10.7%	1,397,575	37.7%	52.
tal I/P	13,683	13,286	-2.9%	12,861	-3.2%	-6.0%	80,767	78,892	-2.3%	74,641	-5.4%	-7.6%	$ 46,917,032	$ 52,513,323	11.9%	$ 54,599,210	4.0%	18.
TPATIENT -																		
ternity	685	695	1.5%	628	-9.6%	-8.3%							$ 65,196	$ 77,306	18.6%	$ 87,016	13.0%	34.
ych	384	429	11.7%	649	51.3%	69.0%							180,343	216,452	20.0%	236,000	9.3%	40.1
om Dep	492	373	-7.2%	587	57.4%	46.0%							48,522	51,126	5.4%	100,617	96.8%	107.
her O/P	28,193	30,102	6.8%	33,444	11.1%	18.6%							6,824,324	8,009,482	17.2%	9,671,300	20.9%	41.
jects	5,137	4,823	-6.1%	3,860	-20.0%	-24.9%							558,507	535,901	-4.0%	513,257	-4.2%	-8.
tal O/P	34,001	36,422	4.7%	39,168	7.5%	12.5%							$ 7,684,891	$ 8,881,207	15.9%	$ 10,010,163	13.5%	30.

R MEDICARE REGULATIONS; MSA (Metropolitan Statistical Areas) FOR NORTH DAKOTA INCLUDE:

Fargo Area - Including St. Luke's Hospital, St. John's Hospital and Dakota Hospital
Bismarck Area - Including St. Alexius Medical Center, Medcenter One and Mandan Hospital
Grand Forks Area - Including United Hospital and Northwood Deaconess Hospital

ATTACHMENT B

Statewide Urban/Rural Comparison
Claims Incurred 01/01/85 - 12/31/87

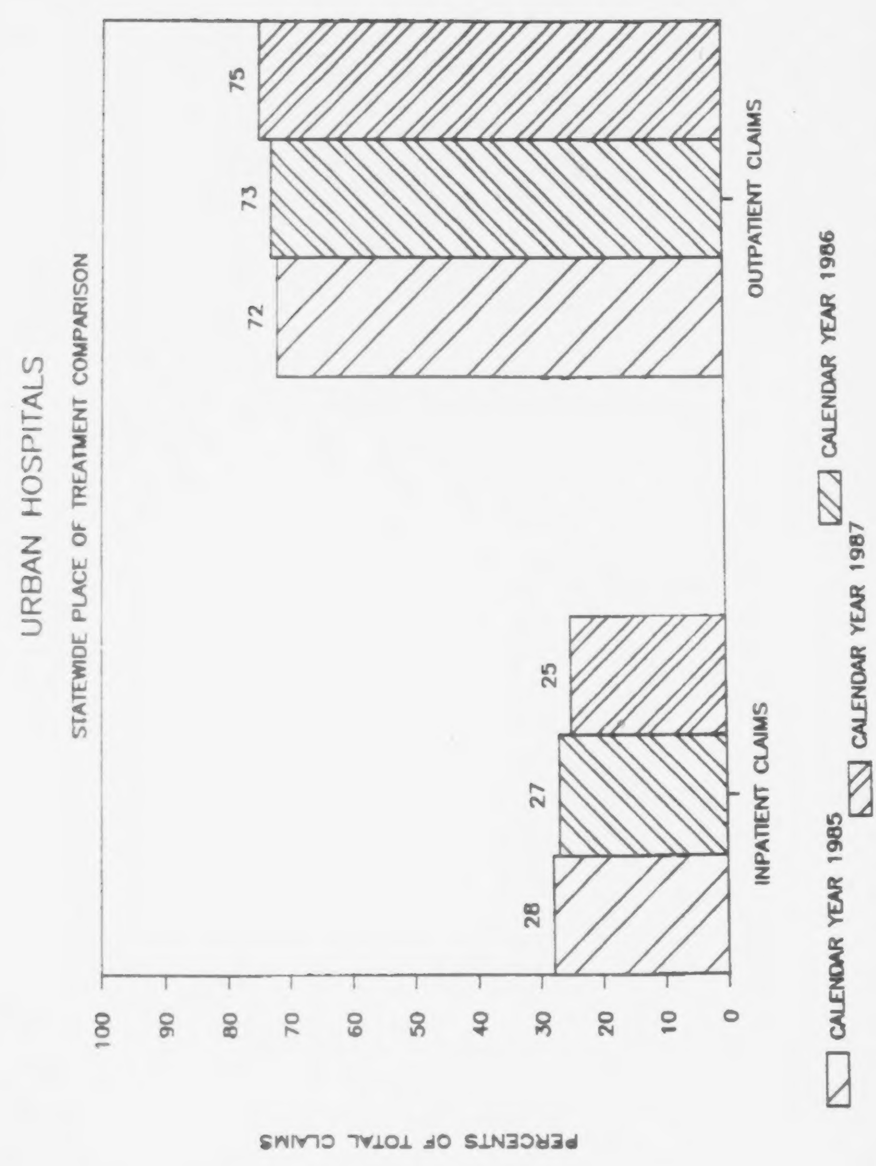
CLAIMS INCURRED AT URBAN HOSPITALS

	1985 Urban ALOS	1986 Urban ALOS	Percent Change (85-86)	1987 Urban ALOS	Percent Change (86-87)	Percent Change (85-87)	1985 Urban Avg. Chg/ Day	1986 Urban Avg. Chg/ Day	Percent Change (85-86)	1987 Urban Avg. Chg/ Day	Percent Change (86-87)	Percent Change (85-87)	1985 Urban Avg. Chg/ Claim	1986 Urban Avg. Chg/ Claim	Percent Change (85-86)	1987 Urban Avg. Chg/ Claim	Percent Change (86-87)	Percent Change (85-87)
NPATIENT -																		
edical	4.89	5.17	5.0%	5.17	0.0%	5.0%	$ 557	$ 614	10.4%	$ 701	14.1%	25.9%	$ 2,719	$ 3,175	16.8%	$ 3,621	14.0%	33.
aternity	3.41	3.44	1.0%	3.22	-6.4%	-5.5%	898	956	6.5%	1,120	17.1%	24.7%	3,057	3,289	7.6%	3,602	9.5%	17.
urgical	5.61	5.64	0.5%	5.59	-0.9%	-0.4%	754	882	16.9%	953	8.1%	26.3%	4,230	4,966	17.4%	5,320	7.1%	25.
sych	13.55	13.76	1.6%	12.90	-6.3%	-4.8%	298	354	18.8%	380	7.3%	27.5%	4,037	4,874	20.7%	4,898	0.5%	21.
hem Dep	23.99	24.52	2.2%	23.25	-5.2%	-3.1%	152	171	12.5%	178	3.9%	17.0%	3,645	4,197	15.1%	4,133	-1.5%	13.
ejects													2,275	2,137	-6.1%	2,089	-2.3%	-8.
otal I/P	5.90	5.94	0.6%	5.80	-2.3%	-1.7%	$ 581	$ 666	14.6%	$ 731	9.9%	25.9%	$ 3,429	$ 3,954	15.3%	$ 4,246	7.4%	23.
UTPATIENT -																		
aternity													$ 95	$ 111	16.9%	$ 140	25.7%	46.
sych													438	505	15.1%	365	-27.7%	-16.
hem Dep													121	137	13.2%	171	24.9%	41.
ther O/P													242	266	9.8%	289	8.6%	19.
ejects													109	111	2.2%	133	19.7%	22.
otal O/P													$ 220	$ 244	10.7%	$ 271	11.1%	23.

ER MEDICARE REGULATIONS; MSA (Metropolitan Statistical Areas) FOR NORTH DAKOTA INCLUDE:

Fargo Area - Including St. Luke's Hospital, St. John's Hospital and Dakota Hospital
Bismarck Area - Including St. Alexius Medical Center, Medcenter One and Mandan Hospital
Grand Forks Area - Including United Hospital and Northwood Deaconess Hospital

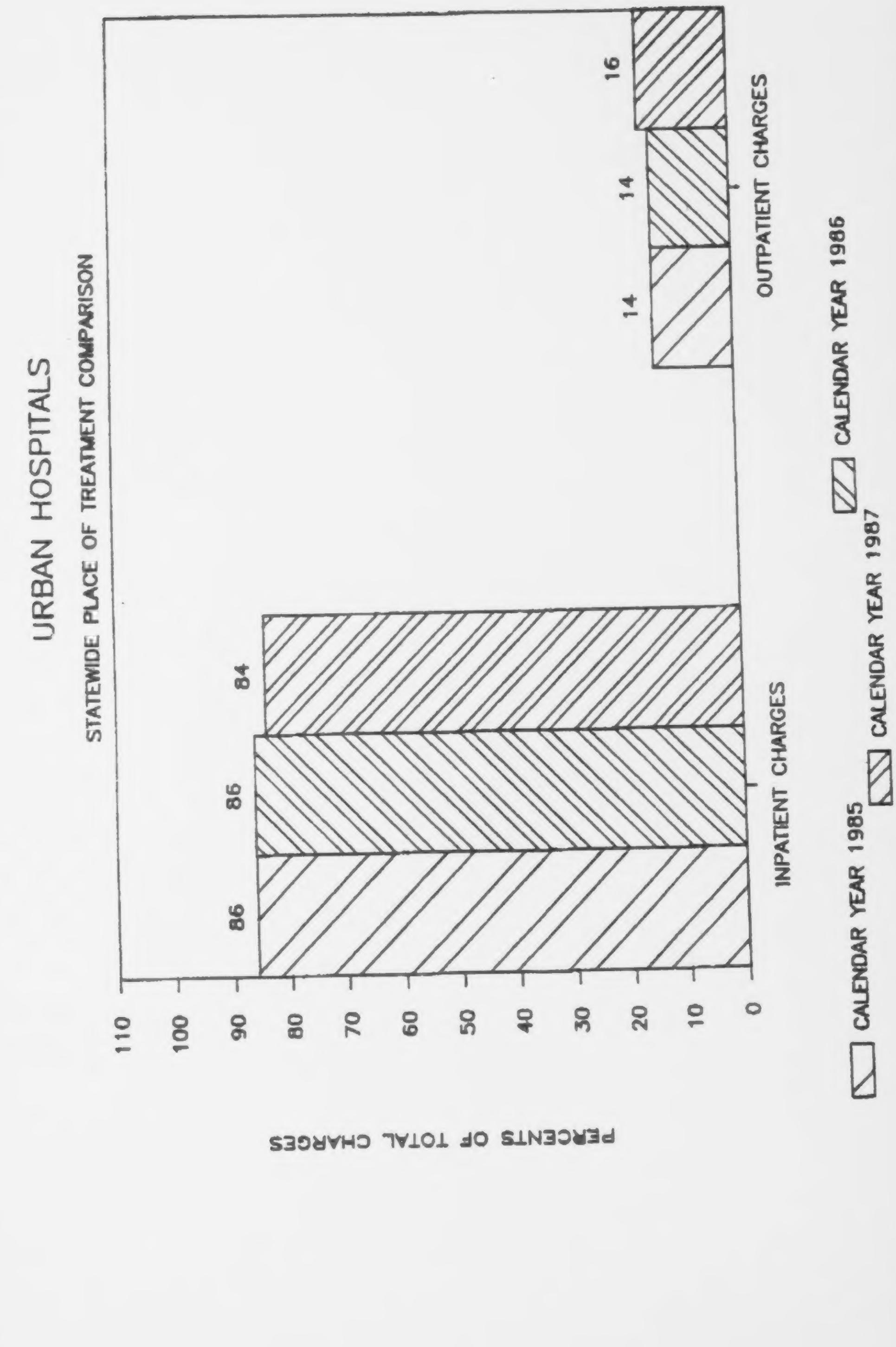
ATTACHMENT C



URBAN HOSPITALS

STATEWIDE PLACE OF TREATMENT COMPARISON

ATTACHMENT D



ATTACHMENT E

Statewide Urban/Rural Comparison
Claims Incurred 01/01/85 - 12/31/87

CLAIMS INCURRED AT RURAL HOSPITALS

	1985 Rural Claims	1986 Rural Claims	Percent Change (85-86)	1987 Rural Claims	Percent Change (86-87)	Percent Change (85-87)	1985 Rural Days	1986 Rural Days	Percent Change (85-86)	1987 Rural Days	Percent Change (86-87)	Percent Change (85-87)	1985 Rural Charges	1986 Rural Charges	Percent Change (85-86)	1987 Rural Charges	Percent Change (86-87)	Percent Change (85-87)
ATIENT -																		
ical	6,438	5,632	-12.5%	5,662	0.5%	-12.1%	26,831	24,531	-8.6%	24,723	0.8%	-7.9%	$ 11,626,371	$ 11,892,958	2.3%	$ 13,491,392	13.4%	16.
ernity	2,253	2,022	-10.3%	1,864	-7.8%	-17.3%	7,275	6,575	-9.6%	5,686	-13.5%	-21.8%	5,151,998	4,809,313	-6.7%	4,813,219	0.1%	-6.
gical	2,682	2,220	-17.2%	2,224	0.2%	-17.1%	12,308	10,242	-16.8%	10,612	3.6%	-13.8%	9,401,007	8,284,490	-11.9%	9,729,777	17.4%	3.
ch	293	276	-5.8%	288	4.3%	-1.7%	4,637	4,348	-6.2%	5,044	16.0%	8.8%	1,311,521	1,282,008	-2.2%	1,600,228	24.8%	22.
n Dep	310	247	-20.3%	273	10.5%	-11.9%	5,354	4,645	-13.2%	4,668	0.5%	-12.8%	1,037,861	962,094	-7.3%	1,051,117	9.3%	1.
ects	340	327	-3.8%	389	19.0%	14.4%							712,404	645,308	-9.4%	676,308	4.8%	-5.
al I/P	12,316	10,724	-12.9%	10,700	-0.2%	-13.1%	56,405	50,341	-10.7%	50,733	0.8%	-10.1%	$ 29,241,162	$ 27,876,236	-4.7%	$ 31,362,101	12.6%	7.
PATIENT -																		
ernity	897	720	-19.7%	855	18.8%	-4.7%							$ 93,173	$ 98,318	5.5%	$ 135,737	38.1%	45.
ch	799	735	-8.0%	788	7.2%	-1.4%							82,542	89,473	8.4%	94,864	6.0%	14.
n Dep	395	308	-22.0%	539	75.0%	36.5%							29,452	33,474	13.7%	74,508	122.6%	153.
er O/P	40,189	44,575	11.0%	54,380	22.0%	35.3%							6,518,747	7,960,903	22.1%	10,621,208	33.4%	62.
ects	7,540	7,853	4.2%	4,588	-41.6%	-39.2%							749,026	830,301	10.8%	352,450	-57.6%	-53.
al O/P	49,820	54,191	8.8%	61,120	12.8%	22.7%							$ 7,473,539	$ 9,012,466	20.6%	$ 11,278,814	25.1%	50.

ATTACHMENT F

Statewide Urban/Rural Comparison
Claims Incurred 01/01/85 - 12/31/87

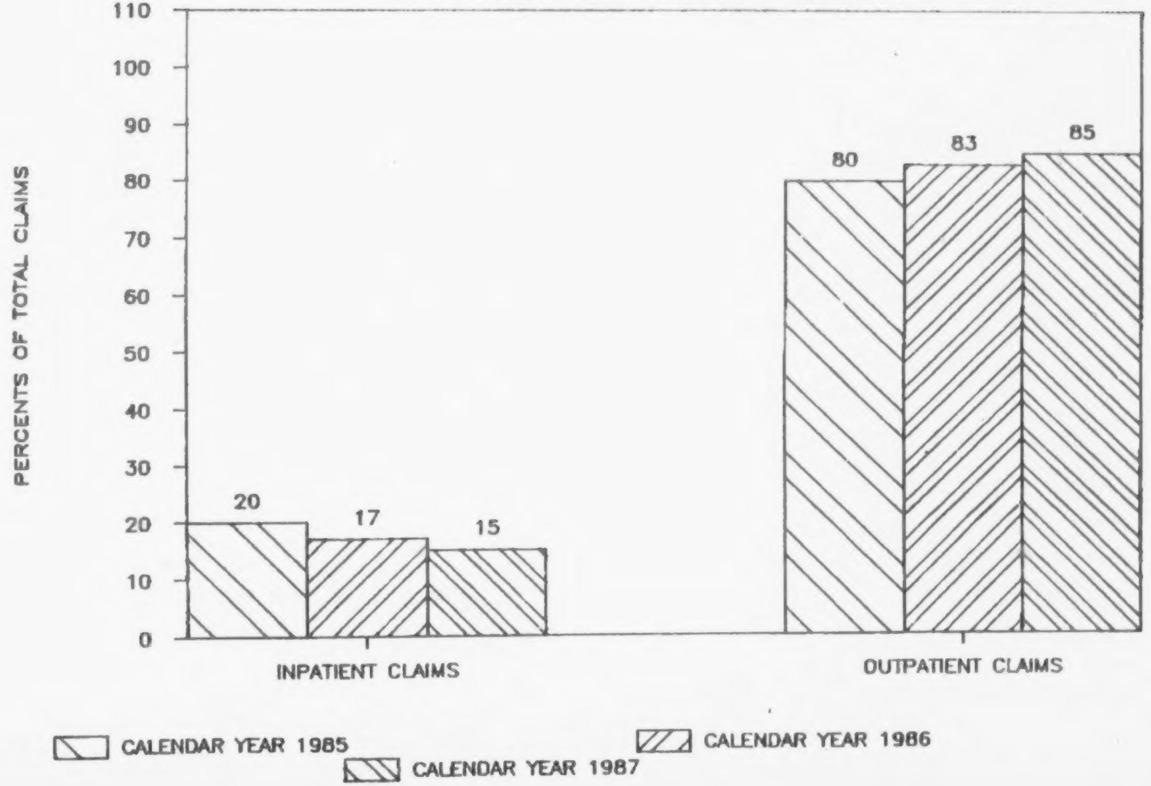
CLAIMS INCURRED AT RURAL HOSPITALS

	1985 Rural ALOS	1986 Rural ALOS	Percent Change (85-86)	1987 Rural ALOS	Percent Change (86-87)	Percent Change (85-87)	1985 Rural Avg. Chg/ Day	1986 Rural Avg. Chg/ Day	Percent Change (85-86)	1987 Rural Avg. Chg/ Day	Percent Change (86-87)	Percent Change (85-87)	1985 Rural Avg. Chg/ Claim	1986 Rural Avg. Chg/ Claim	Percent Change (85-86)	1987 Rural Avg. Rural Claim	Percent Change (86-87)	Percent Change (85-87)
TIENT -																		
ical	4.2	4.4	4.5%	4.4	0.2%	4.6%	$ 433	$ 485	11.9%	$ 546	12.6%	25.9%	$ 1,806	$ 2,112	16.9%	$ 2,383	12.8%	31.
rnity	3.2	3.3	0.7%	3.1	-6.2%	-5.5%	708	731	3.3%	847	15.7%	19.5%	2,287	2,378	4.0%	2,582	8.6%	12.
gical	4.6	4.6	0.5%	4.8	3.4%	4.0%	764	809	5.9%	917	13.4%	20.0%	3,505	3,732	6.5%	4,375	17.2%	24.
ch	15.8	15.8	-0.5%	17.5	11.2%	10.7%	283	295	4.3%	317	7.6%	12.2%	4,476	4,645	3.8%	5,656	19.0%	24.
s Dep	17.3	18.8	8.9%	17.1	-9.1%	-1.0%	194	207	6.8%	225	8.7%	16.2%	3,348	3,895	16.3%	3,850	-1.2%	15.
ucts													2,095	1,973	-5.8%	1,739	-11.9%	-17.
l I/P	4.58	4.69	2.5%	4.74	1.0%	3.5%	$ 518	$ 554	6.9%	$ 618	11.6%	19.2%	$ 2,374	$ 2,599	9.5%	$ 2,931	12.8%	23.
PATIENT -																		
ernity													$ 104	$ 137	31.5%	$ 159	16.3%	52.
ch													103	122	17.8%	120	-1.1%	16.
m Dep													75	109	45.8%	138	27.2%	85.
er O/P													162	179	10.1%	195	9.4%	20.
ects													99	106	6.3%	77	-27.3%	-22.
al O/P													$ 150	$ 166	10.8%	$ 185	10.9%	22.

ATTACHMENT G

RURAL HOSPITALS

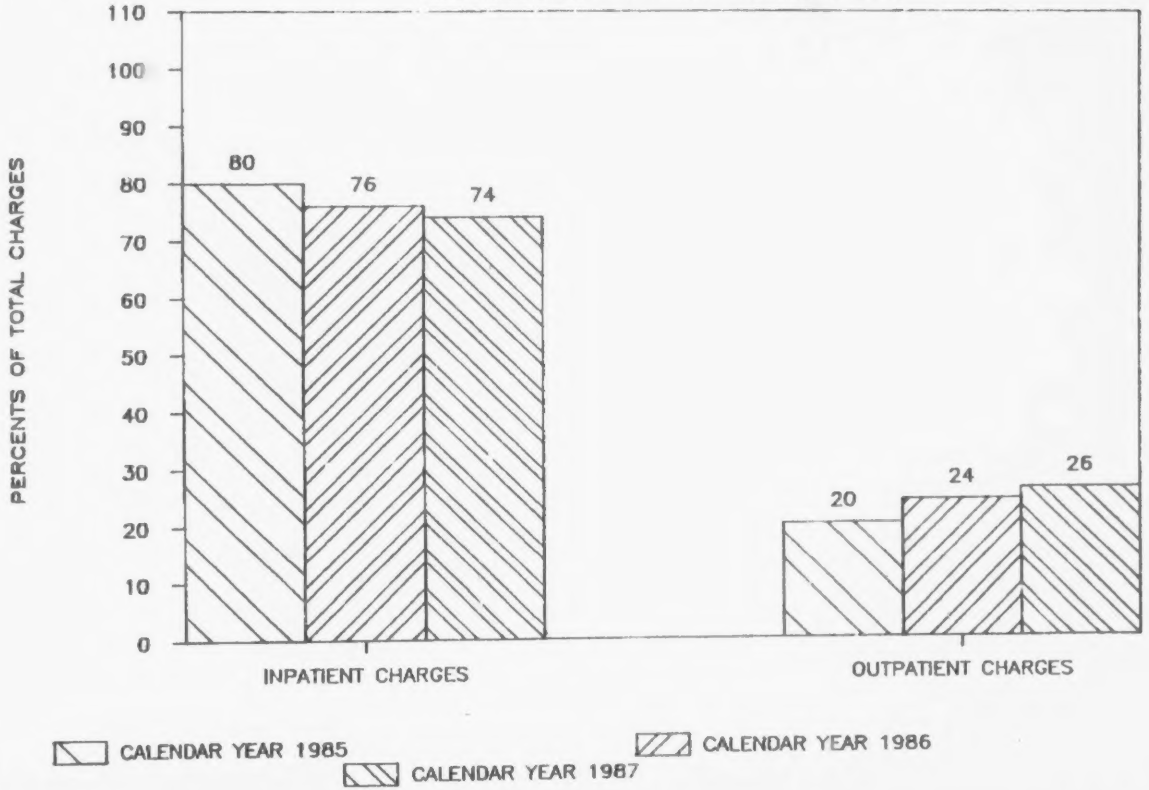
STATEWIDE PLACE OF TREATMENT COMPARISON



ATTACHMENT H

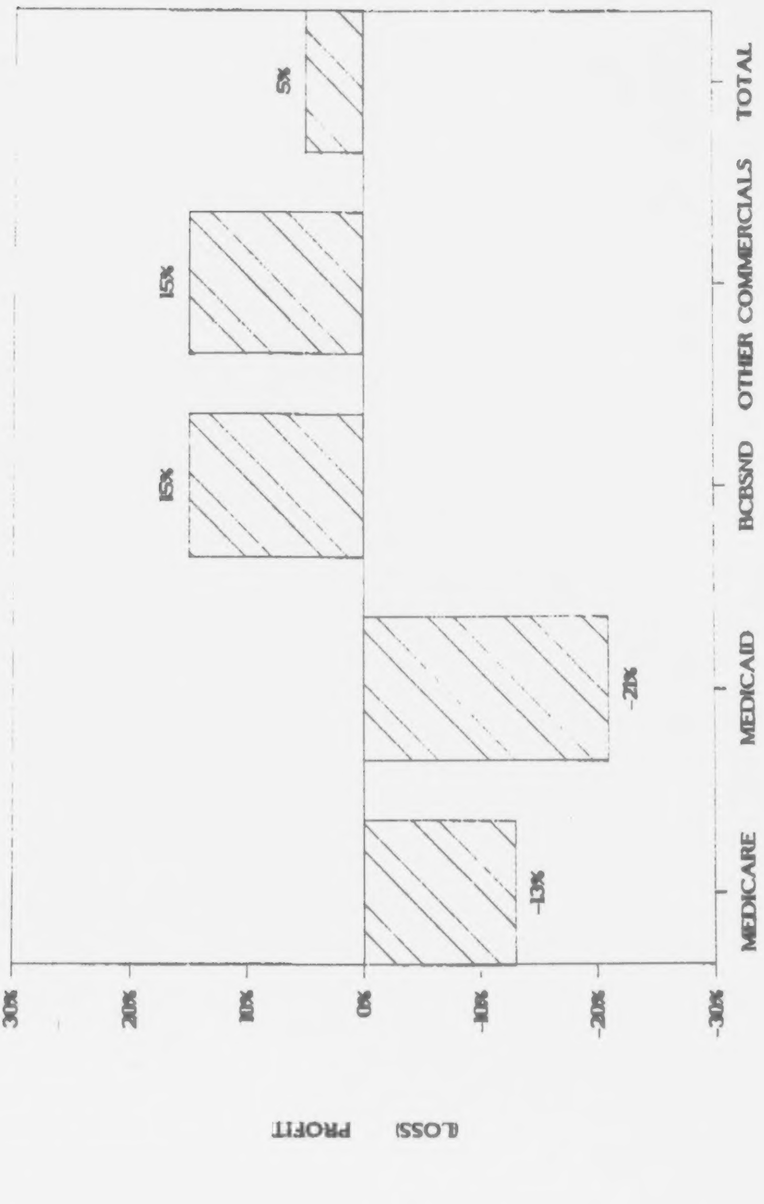
RURAL HOSPITALS

STATEWIDE PLACE OF TREATMENT COMPARISON



ATTACHMENT I

COST SHIFTING ANALYSIS



Senator AUSTIN. Next we'll hear from D.D. Wightman, and D.D. Wightman why don't you proceed. D.D. is the president of Dakota Hospital, and then we will go to Dr. Fiecthner.

STATEMENT OF D.D. WIGHTMAN, PRESIDENT, DAKOTA HOSPITAL

Mr. WIGHTMAN. Thank you, Senator, for allowing me to participate in this hearing. Many of the things that I have prepared are duplication of some of the remarks that have been made, and I have submitted a copy of my testimony to go into the record and will just summarize some of the major points that I've attempted to make in this testimony.

Hospitals as a social instituton have always had as their responsibility the care of the poor. And since the beginning of time this has been a responsibility and it has grown into the 501 C3 corporation which is a nonprofit corporation. It has been pointed out, all of the hospitals in the State of North Dakota are nonprofit hospitals and have as a responsibility because of their tax status to do free care. Dakota does free care. Our social service will find patients who for reasons not of their own neglect, are unable to pay for their health care and we will set that up as without ever billing the patient, will set this up with our board of directors and will approve the cost of the care for those patients. Those that we miss are not specifically identified as the uninsured or underinsured, but end up as a bad debt loss, that for some reason or another are either unable to or unwilling to pay their bill, their hospital bill. This in our particular case has never amounted to an excess of 2½ percent of our gross billings. This last year it was approximately 1 percent or constituted about a half a million dollars.

Our problem as Gary Rudolph demonstrated is that we do not get our full costs from medicare and medicaid. We have what we call a financial requirement for the institution. In other words, we've got to take in so many dollars to pay the payroll, to pay the overhead, to pay the capital indebtedness that we have plus all our of our expenses, and we set our charges accordingly to do that. Medicare and medicaid fall far short of meeting that requirement. We had for medicare in 1988 approximately a 22 percent allowance was given to the Federal government which was below our billed charges. If the Federal government had paid the full amount, which was a little over 2 million, we would have had no difficulty taking care of the uninsured or the underinsured.

So I think as Gary indicated despite the fact that the Federal bill is very big, one of—it is getting too big. One of the two of us are going to have to tell the recipients of medicare that they're not going to get as good as they've been getting in the past. Because I see no way in terms of the financial condition of our health care facilities at the present time that we can continue without the Federal government paying their fair share.

In 1983 there was an agreement made with Congress that the cost based reimbursement procedure under medicare was inadequate and that we needed a change, and we went to the perspective payment system. Congress agreed at that time that they would escalate the payments each year by the hospital market basket plus 1 percent for technological growth. Well, they never ever added the 1 percent, that never ever happened. And to give you an example of how well they have kept their promise, that in 1983, for the fiscal year 1984, the amount of dollars that Dakota Hospital received was based upon previous costs. In 1989, in this fiscal year, we'll get 3 percent less than we got in 1983. We can't live on that. So I thank you for giving me the time.

Senator CONRAD. Thank you very much for that excellent testimony. The problem only gets more difficult to solve, D.D.

Mr. WIGHTMAN. Somebody's going to have to fess up.

Senator CONRAD. Well, we're expecting Justus to do that right now. We've saved him for last because frankly, folks, we've fingered him as the guy that's really responsible for most of the problems. He is going to do a public confession and then we're going to get on to solving this problem.

Dr. FIECTHNER. I have the solutions. Do you want to hear them?

Senator CONRAD. Good.

STATEMENT OF DR. JUSTUS FIECHTNER, ON BEHALF OF THE NORTH DAKOTA MEDICAL ASSOCIATION

Dr. FIECTHNER. Actually I'm here on behalf of the North Dakota Medical Association and on behalf of the Dr. Robert Geston who cannot be here who's the president of the North Dakota Medical Association. I welcome Senator Conrad and his staff to Fargo. I am pleased that the Senate Budget Committee has scheduled this series of hearings in North Dakota to attempt to address the significant problem in increasing health care costs in general and to discuss the crisis in rural health care in particular.

Senator Conrad has asked that we begin by directing our attention to the uninsured in our population. An estimated 35 million Americans are presently without health insurance. Extrapolating that from national figures and based upon some preliminary local studies, the number of North Dakotans without such insurance is between 65 and 80,000. This has been considered by many to be the most important problem facing the health care system today. These individuals are generally self-employed, widows, divorced persons, part-time workers and unemployed—or underemployed.

Only one-third of these uninsured are below the poverty level as defined by the Federal government. They are people who cannot afford the insurance or who are unwilling to purchase adequate coverage. They are often younger people who feel that no harm will befall them until it is too late. When they do seek medical help it is often for complications of illnesses which could be controlled, such as high blood pressure, diabetes and pregnancy problems.

They utilize high-cost facilities and technologies in emergency rooms and intensive care units which would not have been necessary if preventive health measures had been utilized in their local doctor's offices. The costs of such care are then borne by those individuals and their families to some degree, but mostly they are borne by the rest of the populous with health insurance by cost shifting and write-offs by health care providers.

Who is to blame for such an unfortunate situation? Is there a solution to the problem? There's several answers to both questions and they depend upon your point of reference. Overall costs of health care are increasing and comprise of 11 percent of the gross national product.

The public blames physicians and hospitals, insurance companies, lawyers or professional liability costs and high technology equipment cost, but takes none of the blame upon itself for the increasing cost. However, few consumers of health care have an awareness of expenses of their own care until forced to deal with out-of-pocket payments. Employers are very aware of such costs because of the health care benefits they must provide for their employees and they are the most vocal of protestors at the present time, yet they are the ones who are unwilling to provide health insurance for their part-time employees and are defenders of the tax exempt status of their health care contribution.

Insurance companies blame businesses and hospitals for giving too much care and too much expense, yet are unwilling to insure those individuals with the most need for the care. Physicians and hospitals blame the government because of its rules in bureaucracy and because we blame the govenrment for almost everything anyway. What about solutions? Most of us accept that something must be done about the current situation. In fact, most Americans support some type of national health program. A recent survey stated that 56 percent of physicians now feel that the time has come for such a program, but what type of a program? Socialized medicine with its restrictions of care and long waits for elective surgery and high technology procedures will not be tolerated by the American people. Canada and England are examples of this where a two tiered system of care is rapidly growing, one for the rich who can afford private medicine or coming to the U.S. for care, and one of the rest of the people dependent upon the national health care system.

How about the Massachusetts plan which is probably doomed to failure by current inflicting regulations and by too restrictive constraints upon the medical profession? A federally mandated program for health care coverage by employers has been proposed by two famous statesmen, Richard Nixon in 1974 and Edward Kennedy in 1987. Both proposals have been viewed as too expensive in a govenrment already plagued by red ink. Perhaps the answer lies in a recent proposal by two Stanford economists based upon the principle of managed competition, utilizing a somewhat complicated system of State based public sponsors of health care which utilizes current insurance mechanism, a mandated policy of employers' sponsored health coverage, a subsidization of nearpoverty level and small business related individuals and a reward based system for efficient and quality control health care providers.

I do not have the right answer to the dilema, but I can tell you that the best solutions obtained for any problem is through communication such as taking place today. This communication must involve consumers, health care providers, business leaders, government agencies and insurance people. We must not throw the baby out with the bathwater by destroying the best health care system in the world as a quick fix solution to this economic problem. Thank you.

Senator CONRAD. Thank you, Dr. Fiechtner. I really think you did an extremely good job of summing this up because we're sort of in this posture, everybody is to blame and nobody is to blame and somehow we're going to have to struggle our way through this. There's nothing that's much more important to us as a society than health care, and we've got to find a way to deal with this set of problems.

[The prepared statement of Dr. Fiechtner follows:]

PREPARED STATEMENT OF DR. JUSTUS FIECHTNER

On behalf of Doctor Robert Geston, President of the North Dakota Medical Association, I welcome Senator Conrad and his staff to Fargo. I am pleased that the Senate Budget Committee has scheduled this series of hearings in North Dakota to attempt to address the significant problem of increasing health care costs in general and to discuss the crisis in rural health care in particular. Senator Conrad has asked that we begin by directing our attention to the uninsured in our population.

An estimated 35 million Americans are presently without health insurance. Extrapolating from those national figures, and based upon some preliminary local studies, the number of North Dakotans without such insurance is between 65 and 80,000. This has been considered by many to be the most important problem facing the health care system today. These individuals are generally self-employed, widows, divorced persons, part-time workers, or unemployed. Only one-third of these uninsured are below the poverty level, as defined by the federal government. They are people who cannot afford the insurance or are unwilling to purchase adequate coverage. They are often younger people who feel that no harm will befall them, until it is too late. When they do seek medical help, it is often for complications of illness which can be controlled such as high blood pressure, diabetes, and pregnancy problems. They utilize high cost facilities and technologies in emergency rooms and intensive care units which would not have been necessary if preventative health measures had been utilized in their local doctors' offices. The costs of such care are then borne by those unfortunate individuals and their families to some degree, but mostly they are borne by the rest of the populace with health insurance by cost-shifting and write-offs by health care providers.

Who is to blame for such an unfortunate situation? Is there a solution to the problem? There are several answers to both questions, and they depend upon your point of reference. Overall costs of health care are increasing and currently comprise 11% of the Gross National Product. The public blames physicians and hospitals, insurance companies, lawyers (for professional liability costs) and high technology equipment costs, but takes none of the blame upon itself for the increasing costs. However, few consumers of health care have an awareness of expenses of their own care until forced to deal with out-of-pocket payments. Employers are very aware of such costs because of the health care benefits they must provide for their employees, and they are the most vocal of protestors at the present time. Yet they are the ones who are unwilling to provide health insurance for their part-time employees and are defenders of the tax-exempt status of their health care contributions. Insurance companies blame physicians and hospitals for giving too much care at too much expense, yet are unwilling to insure those individuals with the most need for the care. Physicians and hospitals blame the government because of its rules and bureaucracy (and because we blame the government for almost everything anyway!).

What about solutions? Most of us accept that something must be done about the current situation. In fact, most Americans support some type of national health program. A recent survey stated that 56% of physicians now feel that the time has come for such a program. But what type of program? Socialized medicine, with its restrictions of care and long waits for elective surgery and high technology procedures, will not be tolerated by the American people. Canada and England are examples of this, where a two-tiered system of care is rapidly growing—one for the rich who can afford private medicine (or coming to the U.S. for care), and one for the rest of the people, dependent upon the National Health Care System. How about the Massachusetts plan, which is probably doomed to failure by current conflicting federal regulations and by too restrictive constraints upon the medical profession? A federally mandated program for health care coverage by employers has been proposed by two famous statesmen, Richard Nixon in 1974 and Edward Kennedy in 1987. Both proposals have been viewed as too expensive in a government already plagued by red ink. Perhaps the answer lies in a recent proposal by two Stanford economists based upon the principle of "managed competition", utilizing a somewhat complicated system of stated-based "public sponsors" of health care, which utilizes current insurance mechanisms, a mandated policy of employer-sponsored health coverage, a subsidization of near-poverty level and small business-related individuals, and a reward-based program for efficient and quality controlled health care providers.

I do not have the "right answer" to the dilemma, but I can tell you that the best solution is obtained for any problem through communication, such as is taking place today. This communication must involve consumers, health care providers, business leaders, government agencies, and insurance people. We must not "throw the baby out with the bathwater" by destroying the best health care system in the world as a quick-fix solution to this economic problem.

Senator CONRAD. We've certainly heard I think today all of the elements of the problem that we confront or let's put it this way, the challenge because it really is a challenge; and anytime there's a challenge, there's an opportunity to make something better. And I must say I've been very impressed with how forthcoming all of the witnesses have been here today. I think this is an awfully good start to being honest with each other about what we see.

I would be very interested in the reactions of the three of you given your differiing perspectives. And if the Federal government is to act, what would you like to see the Federal government do? It's very easy and very tempting to say, well, the Federal government's got to solve this problem, and probably it does. But we all know the risks associated with that, how easy it is for the Federal government to make a very serious misstep. What would be the principles that would guide you in making a recommendation to the Federal government on how it ought to proceed from where we are now? Anybody want to—what are the basic things that you would want to say to the Federal government, do this, but don't do this?

Dr. FIECHTNER. Well, I think what I was eluding to at the end is basically that we need to work together to solve this problem, that the government alone cannot solve the problem. We have an excellent system of health care delivery in this country. The problem is there are some people that are not getting that delivery, and what we have to do is provide them access. And at the same time we have to use an approach that is cost effective. We don't want to drive the Federal budget up anymore. What we've got to do is we've got use preventive measures which will save us money in the long run. Some of the things that we heard today about prenatal care et cetera, we're going to save money if we do the right things at the right time. The problem is that the emphasis has not been placed that way. And I think the only way we're going to solve the problem is by continued dialogue in working out these problems.

Senator CONRAD. D.D., would you want to tackle that problem?

Mr. WIGHTMAN. I think that—well, first of all, the hospital is a social institution and I think the problem has to come, the solution has to come from society. Now between the providers and the politician, I think we can give society the necessary push to bring about a decision. And I think the first decision that we've got to push for is what constitutes basic health care? What is acceptable to the public? what is acceptable as access to the system? Medicare has designed a specific schedule to get rid of most rural hospitals by not paying them enough to stay in business. So then the question comes of access, and I think we have to define what should the rancher in western North Dakota have in terrms of access to the health care system and then define what services shall be available to him.

Now, again, I think this is something that society's got to decide, but certainly I think it'd be the responsibility of the health care provider and the politician to push them into that decision. Then I think we can get down to the cost and what shall be reimbursed and what shall not be, but I think we have to design the system at the basic level.

Senator CONRAD. Jim, do you want to——

Mr. AUSTIN. I would certainly agree with both gentlemen, Mr. Chairman. I would also hope that some day we would be able to get some of our urban politicians and regulators out here to the rural area. It seems to me that when we discuss health care issues, et cetera, at the congressional level or even at the bureaucratric level, we tend to think about New York, Washington, DC, Minneapolis, et cetera, and that's not the real world out here in rural America. We have different problems that need different solutions. So I would hope that some day, Senator, you would get some of your urban colleagues to join you on one of these trips out to North Dakota so they can see how difficult we do have it in health care in rural America.

Senator CONRAD. Very good point. I'd look foward to doing that.

Let's not miss the opportunity to hear from people who are here who may have a question or a comment that they very much want to place. Let's open it up to the audience. Now, again, my thanks to this panel. I appreciate very much your being here.

Questions or comments that you'd want to make? Yes, sir, if you'd go to the microphone and identify yourself for the record.

Mr. BUTLER. I'm Dave Butler from Fargo, North Dakota. They talked about competition in the medical industry and I think Insurance Commissioner Pomeroy talked about the pricing and the availability of information about the pricing and how price competition goes on. But one of the aspects that hasn't been mentioned yet and I think is very important in the concept of competition, as I know it, is when somebody has a machine that has an engine in it, they need repair on their engine, they can go up and down the street and buy parts from various different sources with various different qualities and at various prices on them. They make those choices. And usually the person running the machine, a truck or a farm tractor, whatever, knows something about his engine and is comfortable about making decisions and choices when they're purchasing services of repair of their machine or deciding on what qualities of how much they're willing to pay for on the parts, they can but used parts, they can buy parts made in Italy, they can buy parts made in America, it may have various technical qualities.

I feel the majority of people that buy medical services aren't real comfortable with our bodies. We can't decide yes and no what we're going to do or not do comfortably. We have to listen to the people that have the most knowledge and of course nobody knows all facts about the body, so it's not an exact science. We listen to our physicians advise us on what they think we should do or not do. We go to the places where they normally operate. We don't stop and say, well, hey, wait a minute, I need this emergency treatment, I'm going to find out a price and I'm going to find out which place has got a better service and so on. And historically in our State some of those decisions have been made that we will go to Rochester or Minneapolis or wherever for them.

I think that when the medical industry's talking about competition, and I'm very pro free enterprise. I'm very pro competition. But competition in the medical business is not like any other business. The person going in and getting the services doesn't pay the bill. They pay part of it sometimes, but many times they aren't in—aren't directly involved with paying for the bill when they get their services.

And so when it's being discussed in the Congress and in our other places, I think this thing of competition in the medical industry has to be couched with some definitions of what do they mean and how do they make those choices and how does a buyer make those choices? I think that in our State we have built way more facilities and purchased technology than the population in this State can afford. And historically we've had to go to Rochester or Minneapolis or someplace else for certain kinds of treatment, and I think that the public would accept the idea that we're going to have to continue to do that. We can't have everything in our area immediately accessible. It'd be very nice to have them. Just like everybody else has said, if I have an auto accident our in the middle of North Dakota, I'd love that helicopter to pick me up and save my life, too. I want the best I can get. But as has been said, the population has to stop and say where do we draw the line and how many helicopters, how many new buildings, how many cancer treatment facilities in our State do we need, and can we afford it? And as a businessman, I say we've got to say no to many of those things. And the business community is paying all employers are paying for a lot of medical costs should be involved with the providers in helping the public to come to those decisions. Thank you.

Senator CONRAD. Thank you very much, Dave. Other questions or comments or suggestions? Yes, sir.

Mr. HENDRICKSON. My name is Harold Hendrickson, and I'm a retired businessman living in the city of Fargo.

Senator CONRAD. Welcome.

Mr. HENDRICKSON. I had a question that I wish I could have directed to a representative of either Dakota or Fargo Clinic. Last year in 1988 I'm quite sure one or the other of the two purchased a very expensive piece of equipment amounting to several thousand dollars, and in very short time the competitive organization bought the same piece of equipment; and my opinion is that the two could have worked in conjunction and utilized the machine. I don't think the machine is necessarily portable, but I think the patients generally are. So when you speak of competition, I agree that competition is the lifeblood of private enterprise, but that kind of competition we don't really need.

Another thing that comes to mind is if we're going to continue with our health care in its present state, I don't see any alternative but socialized medicine on a controlled basis. By control I mean that we as participants should certainly pay a given fee for socialized medicine.

Senator CONRAD. All right. Other comments or suggestions, questions? Yes, sir, and then we'll go right across. That gentleman right there and then the gentleman there.

Dr. LITTLE. I'm Dr. Little from Mayville, North Dakota. I am an old-time country physician. I still make house calls. I still make farm calls, so——

Senator CONRAD. Let's give him a hand.

Dr. LITTLE. When I started or a few years ago when a person came into our hospital with a heart attack, we put him to bed, there was very little we could do for him. About 15 to 20 percent died. Since then we have added a coronary care unit which has private duty nurses, has constant monitoring, medication, this type of thing. Our death rate has dropped down to about, oh, 3 percent. Recently they came out with something new called TPA. If you get somebody with a heart attack, almost immediately if you get this TPA, it reduces the heart attack or stops the heart attack, the only problem is its $2200 per shot.

Senator CONRAD. How many shots would a person need?

Dr. LITTLE. One, and usually they live after they get it, sometimes they don't. I guess what I'm getting at is I also have a son-in-law who took part of his surgical training in England. When he was there he was very disappointed and very disgusted because at age 55 you had lived as long as you were supposed to live. You were not entitled to any operations, you were not entitled to any so-called other than go home and if you live, you live, if you don't live, you die. This is one of the things that maybe our country is coming to. I can see there's no way we are going to stop this $50 or $500 billion cost unless we start limiting care.

I don't—when I have my heart attack, I sure want the TPA, but I don't know that I can afford the TPA, and I don't know whether our country can afford the TPA. So it's possible that all of our participants have said we've got to have something understandable of what the people in our USA are going to accept as adequate care. Do you go into a coronary care unit when you have a heart attack or don't you? And I think until we decide on what we need as far as what is adequate care or what are people willing to accept, I think our costs are going to go up and there's no way to stop it. Thank you.

Senator CONRAD. Thank you very much. Yes, sir.

Mr. STREGE. I speak very loudly, so I don't think I need that.

Senator CONRAD. If you'd just identify yourself again for the record that would help.

Mr. STREGE. My name is Strege, I spoke here before. One remark I want to make has to do with catastrophic health insurance. Kent Conrad made note of the fact that he sent out a questionnaire and 85 percent of the people said they were for this catastrophic health insurance. But in that questionnaire it wasn't very well worded and what the additional cost, the additional tax would be; and that's the reason they voted 85 percent for. If you were to send out a questionnaire explaining that a little bit better, I'm sure the response would be completely different and the people definitely would think something should be changed.

And the part that's bad is there's a cap of 28 percent on our individual income tax, and we're added—at a given point were added

15 percent, we have a 15 percent surcharge. And in reality some of our people are paying over 40 percent on some of their income, but the wealthy people are still paying 28 percent. It's so goddamned unfair. Something has to be done about it. And if you take a questionnaire in this room, they'll tell and they'll repeat it and repeat it. So think about it and these bills are in Congress right now. Think about it very soundly, Senator Conrad, we do need a change in there. We do need this insurance, but it isn't fair the way it is.

Senator CONRAD. Thank you very much. Let me say two things. First of all, I agree with you. It needs some alteration. But I also want to say to you on the question of the questionnaire I send out not being clear. It's as clear as can be. I've got a copy of it right here, and it says right at the top, paying for the catastrophic health care bill. On this side it's what the benefits are. On this side it's how you pay for it. And here's what it says. I don't know how it could be more clear. To pay for the above increases, the new law increases premiums, that's the first sentence. Explains currently what people pay and its says this, the new bill raises the basic premium by $4 a month in 1989. All enrollees pay the basic premium. Those with incomes above certain levels will also pay an income based supplemental premium. The supplemental premium will be $22.50 per person for every $150 of annual tax liability in 1989. The premium will be paid when filing income tax returns. That's precisely correct. That's exactly how it works.

Mr. STREGE. At that income level though? You didn't say what income level, did you?

Senator CONRAD. For everybody who has, every $150 of tax liability, you pay $22.50 of supplemental premium. Then in addition to that, we provided a chart that was done by the Joint Tax Committee based upon 200,000 actual tax returns that shows for various income categories the basic premium, the supplemental income based premium, total premium per enrollees. Now, I don't know how you could do much better than that?

Mr. STREGE. The income level where that starts, you didn't have that in there, did you?

Senator CONRAD. Yes.

Mr. STREGE. What does that say?

Senator CONRAD. These show the income levels 10 to 15,000, 15 to 20,000. I mean they're ranges, I'll grant you that because we simply couldn't put in every iteration.

This man wanted to——

Mr. THELAN. May name is Dennis Thelan, and I'm an insurance agent.

Senator CONRAD. Welcome.

Mr. THELAN. As I was watching that chart, I noticed that the increase in health costs almost completely followed the introduction of medicare, and that involves getting the Federal government involved with our health care. So it just surprises me that there's anybody in the country that is excited about having more government involved in health care. Please do not let them do for health care what they've done for the farmer and the railroad. Thank you.

Senator CONRAD. All right. Thank you very much. Other comments or suggestions? Yes, sir.

Unidentified Speaker. Can you take publications instead of taking time? Can I leave you my literature?

Senator Conrad. Absolutely. We welcome anything.

Unidentified Speaker. I was going to volunteer to solve the problem. Can I do that tomorrow in Grand Forks?

Senator Conrad. All right. Other questions or comments? Yes, Ma'am.

Mrs. Warner. I'm Pauline Warner from Wahpeton, and I wish some of the gentlemen were here that were here before. My question is if the local clinics are so concerned about keeping health care costs down, why dont they accept assignment? Is there anyone here that can answer that?

Senator Conrad. Dr. Knutson.

Dr. Knutson. Yes.

Senator Conrad. Maybe you can just describe briefly what assignment is so people understand that.

Dr. Knutson. I'm not sure how knowledgeable I am about it, but it's what is referred to is the State provider physician or health care provider physician or health care provider whether or not to accept as payment in full for a service charge the amounts offered under the Medicare Program.

I believe—I can answer for my own organziation. I don't know about other providers in the Fargo-Moorhead area. Our policy is that we accept medicare assignment on a case by case basis depending upon what other insurance resources are available and what the financial aspect situation is for the client, so that we do accept, as I say, selectively accept assignment. In my own practice, about 50 percent of my practice is strictly with medicare patients. You know, all of those situations basically I accept assignment for the services provided. It is not a blanket policy however.

Senator Conrad. Any additional questions or comments? If not, let me just—oh yes, sir.

Mr. Warner. Senator, I think maybe they can all hear me from here.

Senator Conrad. All right. If you'd identify yourself.

Mr. Warner. My name is Cliff Warner, and I see my wife had a word so I thought I might have one.

Senator Conrad. You bet, I have that problem with my wife, too.

Mr. Warner. The thing that I—one of the things that the North Dakota Medical Association could probably do to help alleviate some of the terrific costs that are being incurred in the last 30 days of life would be if they would support and make a note that they do support the living will. There is no bills in the State legislature right now that are—we have been before the legislature, this is the third term and it looks this year like it might be past. But I think with the living will being functioning, that an awful lot of people could make that decision prior to their sickness and those costs can be eliminated by choice.

Another thing, too, another thing very expensive is the premature baby. And here again I'm talking again now about maybe if the hospitals would accept the young people into the emergency rooms or into their—for care purposes before the youngster was born and then had to spend $30, $60, $80, $90, $100,000 to keep that youngster alive; and if they would probably provide a little prenatal care, things wouldn't be as difficult.

Senator **Conrad**. All right.

Mr. **Warner**. Those are two very expensive ends of—continue that are costing dollars.

Senator **Conrad**. Thank you very much. Let me just say that I appreciate very much the attendance and participation of all of you. I think this has been a very good hearing. We've certainly identified a lot of issues, heard from a lot of different perspectives. Tomorrow we'll continue with the question of long-term care, and then Thursday in Minot the question of the rural urban differential. With that, we'll declare this hearing before the Senate Budget Committee closed. Thank you very much.

[Whereupon, the above proceedings were concluded at 1:45 o'clock, p.m.]

February 9, 1989.

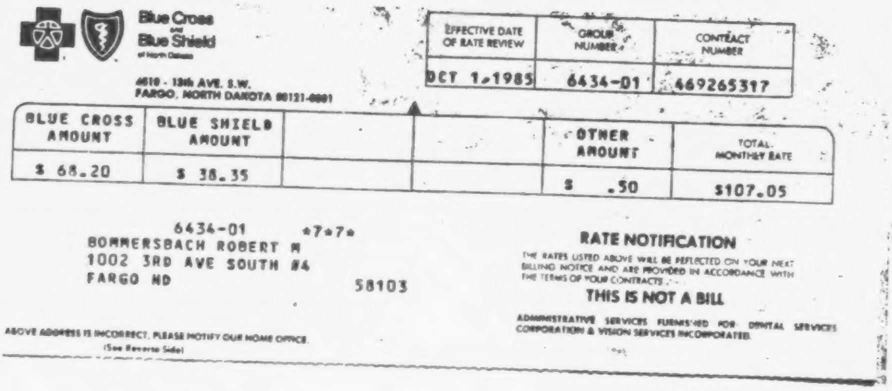
U.S. Senator, Hon. Conrad,
657 2nd Ave NE,
Fargo, ND.

Dear Senator: I would like you to see if you can do something about the high cost for health care. The elderly and the low and medium income people cannot afford to pay this high cost which they are charging for medical care. I have had to drop my Blue Cross and Blue Shield last year on account they raised the monthly payment cost over forty percent I believe and I am on a disability pension and this is small pension for this high cost of living at this time.

You may use this letter and medical papers from Blue Cross showing increase in your stuggle to get good insurance for us poor.

Thank you.

Robert Bommersback.



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OCT 1,1985	6434-01	469265317

BLUE CROSS AMOUNT	BLUE SHIELD AMOUNT			OTHER AMOUNT	TOTAL MONTHLY RATE
$ 68.20	$ 38.35			$ .50	$107.05

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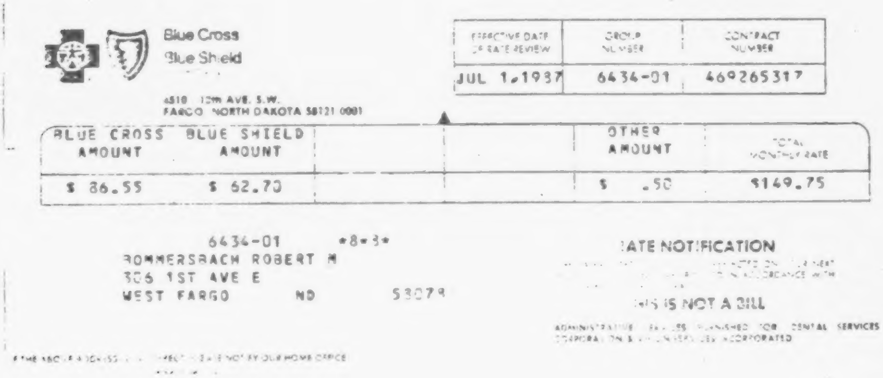

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JUL 1,1987	6434-01	469265317

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$ 86.55	$ 62.70			$ .50	$149.75

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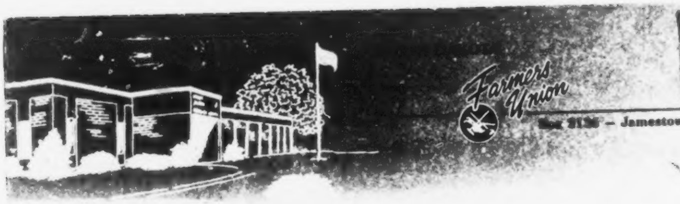

Farmers Union
Box 2136 – Jamestown, North Dakota 58402-2136
Phone: 252-2340

February 10, 1989

Senator Kent Conrad
Senate Office Building
Washington, D.C. 20510

Dear Senator Conrad:

Thank you for providing the opportunity of addressing rural health care issues in this Senate Budget Committee hearing.

I am presenting this testimony as part of North Dakota Farmers Union's mission in representing its more than 32,000 member families. Our committment toward establishment of adequate, accessible health services in rural areas delivered in the most cost effective manner is long standing.

We strongly feel that health care decisions should be based on a comprehensive study of our health care delivery system. We need to take a long term approach to the nation's health care needs in relation to its facilities, services and personnel.

The last decade has shown more change in rural health care delivery than any other time. We have seen a restructuring and reallignment of health care facilities and physician's services. As of now, very few independent clinics and physicians are left in the state.

Many clinics once independently operated have become feeder systems for the medical centers in Grand Forks, Fargo, Minot and Bismarck. This urbanization of health care delivery must be examined in terms of cost effectiveness and the needs of the health care consumer.

The rural consumer voice in health issues has been virtually silent since the federal Health Systems Agencies were discontinued due to lack of funding. The urbanization of health care has accelerated the rural consumer having no real voice in determining where the health dollar investments are made. Providers control those dollars.

We have heard repeated incidents of rural families dropping or reducing their health insurance coverages. Individuals have postponed health care treatment ultimately leading to higher health expenses due to aggravated circumstances. Smaller hospitals are in trouble struggling to keep their doors open and provide services to their communities.

In an attempt to develop controls to cut costs, rural hospitals are penalized while encouraging further urbanization.

The need is apparent to rationalize the spending of our health care dollars according to the public health needs rather than responding to the present system.

Our present system seems to be driven on the basis of a payment schedule rather than one of the overall benefits to the nation's health.

In making a long term plan for the nation's health, serious efforts might be made to provide public funding for health care education and environmental concerns such as cigarette smoking, drug use and dealing with hazardous chemicals.

Further study might point out rural hospitals are becoming intensive care treatment centers moving patients through them at an increasingly fast pace. A long term approach is necessary to address rural hospitals and the services they provide.

A long term plan could provide for clinics being staffed by qualified nurse practitioners to allow improved access to home health care, health promotion and health maintenance.

In such a plan, home health care providers might receive priority, enabling the unnecessary building of more nursing homes.

The plan might suggest that the use of helicopter ambulance service is not as cost effective as other less dramatic means and not as beneficial to the overall consumer health needs in the long run.

And, study might also point out the necessity of developing a comprehensive health policy enabling all people to become fully participating members of prepaid medical, mental, dental, hospitalization plans and nursing home care.

Unfortunately, we do not have such a long term plan that considers all aspects and creative uses of our available resources. At this time, we are looking at pieces rather than the entire health picture. Solving our health care delivery problems in pieces is not the best investment of public and private dollars. We need a better way to rationalize the decisions made in private and public policy.

A comprehensive study of our nation's health care delivery system will benefit every segment of our society, as well as aid in the budget process.

North Dakota Farmers Union is conducting a statewide health conference March 29 and 30 to analyze health care issues from a rural perspective. Prior to the conference, our county leadership will conduct a survey that will determine information about our membership's insurance coverage: whether they carry health insurance, if they have changed coverage recently and why it was changed. We will be happy to forward the data gathered in our survey once it is tabulated.

We commend your committee's work to consider the nation's health care needs and how we as citizens will pay for good health. We will all benefit from researching new ways to continue improving the quality of life in our state.

Sincerely,

NORTH DAKOTA FARMERS UNION

Denise Spanjer

Denise Spanjer
Director of Member Services

DS:db

Mental Health Association of North Dakota
A Division of the National Mental Health Association

P.O. Box 160 - Bismarck, North Dakota 58502 - Phone 701/255-3692

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March 1, 1989

Senate Budget Committee
c/o Senator Kent Conrad
361 Dirksen
Washington, DC 20510

WRITTEN TESTIMONY REGARDING RURAL HEALTH CARE CONCERNS BY CARRIE SMALL, HELP-LINE COORDINATOR FOR THE MENTAL HEALTH ASSOCIATION OF NORTH DAKOTA, BISMARCK, ND 58502

Thank you for giving us the opportunity to express our concerns that we have on rural health care in North Dakota. My name is Carrie, I am the coordinator for a very special project of the Mental Health Association, the HELP-LINE. The HELP-LINE is a state-wide toll/free 24-hour crisis intervention/information and referral service.

We deal daily with many areas of stress, but the issue being heard now is one of the need for affordable and available health care for the rural North Dakotans.

Many of our callers do not have any type of health insurance, nor life insurance for that matter. Financial problems in the family or farming operation make it impossible for many to keep up with monthly insurance payments. Many rural families, in the past, used to be able to pay insurance premiums once a year, in the fall after the cash crops were sold, or cattle were taken to the livestock salesbarn. For many, this is not a option anymore, they either have sold out, or cut back and the lender is now taking the total proceeds for payment on the loans and not releasing money for family living expenses like they used to.

In the state of North Dakota after you have proven yourself to be financially elgibile for medical assistance you still must be under the age of 21 or over the age of 65. There are thousands of low-income people between the ages of 21 and 65 that are neglecting their own health because of the cost of health care.

United Way

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Many of these families, already under great financial stress are acquiring huge medical bills that will take a life time to pay. Judgments from Medical Collections are being added to the already pile of pending financial responsibilities and this is only if they are accepted as patients of a clinic or hospital. Many are denied services because of inability to pay.

I have spoken with a young man, who is 23 years old. He has peridontal disease, there is no program that will help this young man, who is working two part time jobs, just making enough to pay the rent and put groceries on the table. Fortunately, the HELP-LINE has developed a network of people and agencies across the state and through this group of wonderful people who care and want to help, we found a dentist and oral surgeon that were willing to defray a large part of their costs and work with this young man, and help him through this crisis in his life.

There was also the 40yr old farmer from the western part of the state that has been having chest pains for some time. His wife called, very upset and wondering what she could do. They didn't have any health insurance and he refused to go to the hospital or clinic and get checked because it would just be another bill that they couldn't pay. But consider what would have happened if he would have refused to go and it was more serious. A heart attack at home, 75 miles from a hospital. The ambulance bill, the emergency service and I do not even know what the standard bill is for a victim of a heart attack, plus if he would live, the cost of medication for his heart!!! This is happening!

People don't have medications for their heart, diabetes, infections or many other illness, because they do not have the money and are making due, you can look at it, as either a slow suicide by the victim or murder by the system.

This is a issue that is close to my heart, as a farm wife and mother of two children, I know the fear that the rural family is living with daily, hoping that for today, nothing will happen to the children and hoping that no one needs medication.

I thank you for showing your concerns and responding to the rural Health crisis. If the HELP-LINE office can be of further assistance to you please do not hesitate to call.

Mental Health Association of North Dakota
A Division of the National Mental Health Association

P.O. Box 160 - Bismarck, North Dakota 58502 - Phone 701/255-3692

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February 21, 1989

Senator Kent Conrad
United States Senate
Washington, D.C. 20510

Subject: Crisis In Rural Health Care

Dear Senator Conrad,

Thank you for your letter of February 2, 1989, regarding the Senate Budget Committee Hearings to investigate the Crisis in Rural Health Care. We welcome your leadership in the effort to address the fundamental structural problems in providing health care in rural areas.

The expectations of the people of America are increasing. Health care is seen by the great majority of Americans as a fundamental right to be provided or assured by our government. Yet, that rising expectation is confronted with the reality of the great numbers of fellow citizens who do not have access to health care. We are all groping in the fog toward a mechanism for public provision or public assurance of basic health care services for all Americans.

In this search, we urge continuing awareness of the dimension and importance of mental illness and mental health services as these mechanisms for providing health services are developed. Mental illness is a component of every physical illness and for many Americans it is the primary illness with which they struggle. Mental health services for people dealing with physical illness and mental health services for people facing serious mental illness are essential components of a comprehensive health care system.

A shortage of mental health services is extreme in North Dakota. We have a system of public mental health services through Human Service Centers and private mental health services. The public services deal with the poor and the private services deal with the rich. There is little consultation between these services and no present eye-level efforts to coordinate these services.

The Mental Health Association of North Dakota provides one of the few bridges between the public and private sectors in providing mental health services. Our efforts focus on the

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development of community-based mental health and addiction services through cooperative arrangements between public and private service providers. This is a slow, but necessary process.

As you know, the citizens of North Dakota are going through difficult economic times in which more people are under the pressure of extreme decisions and must reach out for assistance. The HELPLINE of the Mental Health Association has responded to over 4,200 calls during 1988, with referral to available agencies. Personal situations are so desperate and the funds available to maintain our largely volunteer HELPLINE service are so tenuous.

We thank you for your leadership in responding to the crisis in rural health care and your willingness to recognize the component of mental illness and the importance of mental health services in the solution to that problem.

If we can be of further assistance to you in this matter, please do not hesitate to contact us.

Sincerely,

Larry Spears
President

LS:kes
cc: Executive Committee
Liz Magill
Myrt Armstrong

HEALTH & PUBLIC POLICY

Insurance and Women's Access to Health Care: Economic and Political Dimensions

Nancy C. Gilliland, PhD

ABSTRACT. Women's access to health care via insurance is curtailed because of their lower economic status and because health insurance is organized around employment and marital status. Ending sex discrimination in insurance would not guarantee access to care, but congress and the states can take steps to make insurance coverage more available and affordable for women by enacting legislation and by means of the regulatory process. In the end, however, the social policy argument for non-discrimination in insurance may be more compelling than the economic one.

In today's medical economy, access to health care is gained by means of health insurance. Most Americans have some coverage,

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This paper is revised from testimony at a hearing of the Minnesota Commission on the Economic Status of Women in Moorhead, Minnesota, August 8, 1984.

The author wishes to thank Doris Heroff, Betty Jean Pyle, and Anne Kasper.

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private or public, but even those *with* health insurance pay a considerable amount out of pocket for their care. In 1976 the average out of pocket medical expense for a family of 4 was $782 (National Center for Health Statistics, 1979). In 1982 out of every health dollar spent in the U.S., about 28 cents came from direct patient payments. That was almost as much as the 30 cents paid by private health insurance and other private third parties (Gibson, 1983). In addition, approximately 18 million people are without insurance for the entire year, and 16 million for some part of the year (Davis & Rowland, 1983). From this it can be seen that access to care presents a serious problem.

Americans appear to be ambivalent about whether health care is a right that should be guaranteed to all citizens or a commodity for sale by physicians and hospitals. The view that it should be a right is revealed in the case of kidney dialysis. The American public apparently did not feel comfortable with allowing this life-saving treatment to only selected patients. Thus it is now covered for all patients who need it under Medicare. On the other hand, community fundraising efforts to pay for transplants and other such expensive operations are being reported with increasing frequency by the media. Without the money there will be no life-saving operation. This ambivalence is probably an outcome of the contradiction between health and profit in a capitalistic system.

In *The Political Economy of Aging* Laura Katz Olson (1982) pointed out that the problem for capitalist states is to reconcile the need to foster concentration of capital in private hands while still maintaining the legitimacy of the capitalist system as one that serves the public interest. Lacking a national health service or national health insurance, access to health care by means of private insurance has thus far been sufficient to maintain that legitimacy. But women are less well covered by health insurance than men and are beginning to question the system.

Women's access to health care via insurance is curtailed compared to that of men for two major reasons. One is the lower economic status of women, which limits or precludes purchase of health insurance coverage. The other is the way insurance coverage is organized and sold.

THE ECONOMIC STATUS OF WOMEN

In February, 1984, the Census Bureau reported that the proportion of the U.S. population below the official poverty line had risen sharply in the past few years, even when in-kind benefits like food stamps are counted as cash income. Figured either way (cash only or cash plus in-kind), poverty rose by about one-third from 1979 to 1982 (Rich, 1984).

Diana Pearce's term "feminization of poverty" was intended to point out that increasingly it is women who are poor. For example, 2 out of 3 American adults living in poverty are women, and of all families classified as poor, half are headed by women. It is three quarters in the case of poor black families (Pearce, 1984). The 17% poverty rate for older women in 1983 was substantially higher than that of the 10% rate for older men (Rix, 1984). In sum, because of their relatively poorer economic status, women are less able to afford private health insurance.

THE WAY HEALTH INSURANCE IS ORGANIZED AND SOLD

Health insurance coverage is less available to women than to men not only because of their economic status, but also because of the way insurance is organized and sold. That is, it is tied to employment or marital status.

Health insurance coverage is a fringe benefit offered by some employers to secure workers' attachment to the job. This works to the disadvantage of women in that the lower-paying, non-union, and less than full time jobs in which women predominate do not typically provide this fringe benefit. More than a quarter of women in the work force are part-time workers according to the Department of Labor's Women's Bureau (1980). Unemployed people who are not covered through work may not be able to afford expensive private contracts, may not be poor enough to be eligible for Medicaid, or old enough for Medicare. Among these are young women whose responsibility for children precludes working, and older women who are unable to find employment for health reasons or because of sex or age discrimination. Clearly there is a need to detach health insurance coverage from employment status—for women *and* men.

Health insurance coverage is also based on marital status. Homemakers, some working spouses, and children are usually eligible for coverage as dependents under the primary wage earner's employment coverage. However, divorced or widowed women may be refused the same coverage they once had under policies held by their husbands.

Employers in Minnesota are required to offer employees or dependents the opportunity to purchase a 12 month extension of coverage under the group policy within 10 days after employees are terminated or dependents are divorced. This extension stops, however, at the time of remarriage of *either* spouse. At that point the insurance company for the group policy is required to offer a "conversion" (to an individual contract) policy. These generally have fewer benefits than were available under the group policy, and are very expensive. Their advantage is that they "lock in" preexisting conditions, including pregnancy.

Having access to an insurance contract that locks in preexisting conditions is particularly important for older women, since chronic illness accompanies advancing age. Without it, they may be refused coverage altogether or relegated to a Comprehensive Risk Sharing Pool if they reside in states where one is available. In 1978 Minnesota was one of only 4 or 5 states with such a plan. Now many more states have them. Although it means access to coverage for people who would otherwise be refused, like the "conversion" policies, it is expensive.

For older women, who are heavily overrepresented among the elderly poor (Rix, 1984), these premiums may be out of reach. According to the Older Women's League, there are 4.5 million women between 45 and 64 without any health insurance. The Report from the White House Mini-Conference on Older Women stated that "Health insurance coverage for uncovered women is the most immediate health issue faced by older women today" (Cavanaugh & Sommers, 1981).

Thus we see that as long as women are in *covered* employment, (or are married to a man who is) they may be protected. They may also be protected against sex discrimination. Federal and state laws now prohibit discrimination on the basis of sex or marital status in group health insurance. In individual contracts, however, the insurance industry is still free to discriminate on the basis of sex.

Federal legislation that would guarantee uniform non-discriminatory practices was introduced in the U.S. House in 1979 and again in 1981 as HR100, called the Non-Discrimination in Insurance Act, and in the Senate as S.372, the Fair Insurance Practices Act. This legislation would end the insurance industry's practice of assigning different rates, benefits, and availability of coverage to women and men. Modeled after other civil rights laws, this law would apply to insurance the same principles of non-discrimination that have already been applied to education, credit, employment, and housing.

The last meeting (the "mark-up") of the House Energy and Commerce Committee on HR100 was held in March, 1984. In that 4-hour meeting HR100 passed, but was so gutted by opponents' amendments that its sponsors voted against their own bill. As Representative Barbara Mikulski (Democrat, Maryland) put it, "HR100, as now amended, works against the very principle of fair insurance it was designed to ensure."

An amendment proposed by Tauzin (Democrat, Louisiana), for example, excluded all individual insurance contracts. Since sex discrimination in group contracts had already been outlawed by recent Supreme Court decisions[1], this amendment had the effect of completely negating HR100.

Another amendment involved maternity coverage. HR100 originally required that all health insurance contracts include maternity benefits. An amendment by Dowdy (Democrat, Mississippi) and Lent (Republican, New York) eliminated mandatory maternity coverage. They argued, incredibly, that men should not be required to subsidize maternity benefits.[2]

HR100 was not moved on to the House floor, but will be reintroduced in 1985 (and every subsequent year until it passes according to proponents). Meanwhile, sex discrimination in insurance remains legal. In a recent development, however, the NOW Legal Defense and Education fund has filed a $2 million class action suit against Mutual of Omaha, claiming the company overcharges women for health coverage. The Civil Liberties Union is considering litigating the problem as a public accommodations issue (Pinzler, 1985).

PUBLIC HEALTH INSURANCE

Women who are not covered by group insurance and are unable to purchase health insurance coverage may gain access to health care through public insurance programs, primarily Medicaid and Medicare. Medicaid is a joint state and federal program to provide health services to certain categories of low income people. Women who are recipients of AFDC are automatically eligible for Medicaid. Others not eligible for AFDC but without resources to meet medical needs may also be eligible for Medicaid. Older women receiving long term care are another group that benefit from Medicaid coverage. Women constitute about 65% of Medicaid recipients (Coalition, 1984).

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[1] State of Arizona v. Norris and Los Angeles Power and Water Department v. Manhart. In these decisions Title VII of the 1964 Civil Rights Act was interpreted as prohibiting unequal treatment on the basis of sex in the insurance and pension plans that employers sponsor for their employees.

[2] According to WEAL, 88% of all single men already have pregnancy coverage under employee benefit plans as a result of the Pregnancy Disability Act of 1978. *WEAL Facts*, February 10, 1984.

Each state sets its own eligibility standards and determines the scope of covered services, though federal law requires that certain services be offered. Elective abortions, a service needed only by women, are covered by Medicaid in only about a dozen states according to the National Abortion Federation.

In fiscal 1983-84 federal funding for Medicaid was cut by as much as $3.1 billion according to the Washington, D.C. Coalition on Women and the Budget in their 1984 publication, *Inequality of Sacrifice: The Impact of the Reagan Budget on Women.* Legislative changes gave states more flexibility both to cut recipients from the program and to demand that they pay a portion of their medical costs.

At the same time changes in AFDC law eliminated thousands of families from that program. In states without a medically needy program (all but 28), this meant a total loss of medical coverage for those families. At least 700,000 poor children lost all Medicaid benefits that way in 1982.

Warshaw (1984) reports Children's Defense Fund statistics which show rapidly increasing proportions of women receiving late (last trimester) or no prenatal care. In Philadelphia, for example, the percent of "no prenatal care" births went from 0.7% in 1980 to 1.7% in 1981 to 2.7% (about 700 babies) in 1982. These babies are three times as likely to die in infancy than those whose mothers received early prenatal care.

The Reagan administration is proposing additional cuts in Medicaid (and Medicare also) for fiscal year 1985-87. They propose to cut costs by requiring all recipients to pay part of the cost no matter how poor they are and requiring states to bear more of the cost burden.

Each state sets its own eligibility standards. In Clay County, Minnesota, for example, as of July 1, 1984 a family of two whose adjusted income was over $431 per month was ineligible for medical assistance. That means that a person working full time at minimum wage is probably not eligible. A "spend down" program compensates to some degree for this extremely stringent eligibility standard to aid people with unusually large medical expenses. It does not help people who are not poor enough to meet this standard and yet are unable to afford "ordinary" medical care.

Medicare is federal insurance for the elderly and disabled persons. It is a main source of access to medical care for that group, yet it pays for only about 44% of their health costs, according to the Health Care Financing Administration. It is estimated that one-third of older women's median annual income is consumed by the uninsured portion of medical costs. President Reagan's 1985 budget proposal would reduce the program's outlays by $19 billion over 5 years, with the "savings" financed out of beneficiaries' pockets (Coalition, 1984).

RECOMMENDATIONS

We have seen that with respect to health care and the economic status of women, there are two kinds of problems. One is discrimination of the sort that requires women to pay more for the same coverage or makes it impossible to buy certain coverage (even if they have the money). The other is lack of any insurance coverage or having to rely on the inadequate public programs. What can states do about these two programs?

With regard to discrimination, state legislators, in their capacity as legislative representatives or as private citizens, can urge the passage of the federal non-discrimination in insurance bills, such as HR100 and S372. Citing life insurance as "proof," opponents of this legislation (i.e., the insurance industry) argue that discrimination in insurance actually *benefits* women. But consider the following information from the Women's Equity Action League (WEAL) and the National Women's Political Caucus (NWPC):

— There is no discount for small amounts of life insurance (women's average is less than $20,000).
— There is no discount for women at earlier ages (when they need life insurance the most.)
— There is typically a high disability waiver premium. Even after paying this high premium the waiver benefit may be useless for women who are homemakers due to the difficulty of proving total disability for homemakers and part-time employees.

The coalition of women's and civil rights organizations that support HR100 and S372 argue that women's disadvantage in health and disability insurance substantially outweighs any possible advantage in auto and life insurance.

This view is not universally held, however, even among those who support non-discrimination in insurance. According to a report by Judith Hale, a research analyst for the Minnesota Commerce Department (1984), for example,

> The economic impact on individual women will vary significantly depending on their particular circumstances. A young women who receives health, life and disability coverage through her employer will pay more due to her increased costs for auto insurance. A 40-year-old woman in similar circumstances will probably not be affected at all. On the other hand, if the young woman needed to buy individual health insurance or the 40-year-old woman chose to buy individual disability coverage, they would each experience considerable cost savings under a gender-equal pricing system. (p. 46)

The two main issues for women buying life insurance are rates and availability of options. At issue in unisex rates is whether or not gender is causally related to risk and therefore a legitimate actuarial consideration. There is a good deal of controversy about this question (e.g., is it gender per se or lifestyle that makes women longer lived?), but even if we grant, for the sake of argument, that gender *is* causally related to risk, the use of gender may be so offensive to standards external to the insurance system as to make its use out of the question (Scanlon & Stone, 1983). The analogous situation, of course, is race, which is a "suspect category" for use in any sort of classification.

That correlations between race and insurance losses can be statistically documented is clear. But variables other than race, such as income and access to education, are better explanations of the losses and are themselves the effects of racism. Thus, if race is associated with insurance loss by means of racial discrimination, it is difficult to argue that it is "fair discrimination" to use race for classification in insurance even though, on the face of it, it appears to be actuarily justified.

A similar argument can be made for the fairness of using gender for risk classification. In the case of health insurance, why *do* women utilize health services more than men? If it is due in part to gender role socialization, economic exploitation (e.g., unecessary hysterectomies), or other such manifestations of the sex-gender institution, then it becomes much more difficult to justify its use.

As Scanlon and Stone (1983) have pointed out, sex-based classification systems are offensive in that they have historically been abused. That is, they have generally favored males over females, just as racial classifications have generally favored whites over people of color.

Despite the insurance industry's massive lobbying and advertising campaign to defeat HR100 and S372, a few companies have already switched to unisex rates and benefits. According to WEAL president Mary Gray (1984), Consumer's United Insurance Company, Equitable Life Assurance, Provident, Paul Revere, Co-op America, Home Life Insurance, and Commercial Union Insurance Company all offer unisex coverage in various types of insurance.

Another strategy states can use is enacting comprehensive nondiscrimination in insurance legislation. The coalition of women's organizations that has been in the forefront of efforts to pass the federal legislation have now begun to urge that state-level HR100's be enacted as well. If one accepts the proposition that the right to buy health insurance and at a price that fairly represents risk is fundamental, however, then federal involvement to ensure minimum standards is necessary. State regulation in an area of federally-protected rights presents complex problems. For an interesting discussion of the state versus federal regulation issue, see *Discrimination Against Minorities and Women in Pensions and Health, Life, and Disability Insurance* (U.S. Commission on Civil Rights, 1978).

States can take significant action without passing new legislation, however, by using the existing regulatory power of state statutes and the office of the State Insurance Commission to the fullest extent. The powers of a state insurance commissioner include revocation of licenses, summoning of witnesses and records, and disapproval of policy forms, applications, and riders.

States can control policy content by mandating the inclusion of minimum standard provisions. New York, for example, mandated inclusion of maternity in health insurance contracts; New Jersey mandated inclusion of alcoholism. However, as Michigan's State Insurance Commissioner pointed out to the U.S. Commission on Civil Rights (1978), if certain benefits are required and insurance companies are still allowed to develop co-payments or deductibles, the intent of mandated coverage may be subverted.

State insurance departments can require that insurers and rating organizations file rates and rate classifications with their offices. These can then be approved or disapproved as unfairly discriminating.

Examination of insurers is done periodically by the state commissioner's staff. Historically the purpose has been to examine financial solvency, but recently examiners have looked also at marketing practices as they affect consumers. Wisconsin has a short section on examination reports devoted to affirmative action. This was instituted on the assumption that a company which discriminates in hiring is likely to do so also in underwriting and classification judgements (U.S. Commission on Civil Rights, 1978, p. 220). More women and minorities should be involved in the whole insurance structure and process, including board members, and insurance commission staffs. A question legislators must ask is, "Has this state ever imposed sanctions related to sex discrimination against any insurance company?"

The following quotation from Gayle Lewis-Carter, an assistant to the Pennsylvania Insurance Commissioner, illustrates how a state insurance commissioner can protect citizens' access to care (U.S. Commission on Civil Rights, 1978):

> It was only this year (1978) in Pennsylvania that Commissioner Sheppard decided he would not grant a rate increase under a 65 program (referring to Medicare supplementary insurance) where the HEW deductible increased. Then, the Blue Cross plans came in and said, "Well, here's our new rate because of this increase in the deductible." What the commissioner said . . . after holding about 8 public hearings that year (was) that he will not grant this rate increase. He doesn't feel that this deductible is warranted. . . . The court upheld the commissioner's authority to decide that this rate increase was not justified and that 65 special contract has to be subsidized like he required because he decided for the (insurance) department that senior citizens and poor people can least afford to pay for this type of insurance and the cost has been escalating much too high and that employee-employer groups and individuals would have to subsidize senior citizens. (p. 720)

It appears that this was an unusual action by an insurance commissioner. Most commissioners, according to testimony of the Assistant Commissioner of New Jersey, come from the insurance industry, and when they leave a department they go back to industry (U.S. Commission on Civil Rights, 1978, p. 212). She described the industry's funding of and presence at regional meetings of the National Association of Insurance Commissioners. In some cases statutes regarding approval of policies and rates were written by the industry back in the forties. As Assistant Commissioner Lewis pointed out, the "constant" in State regulation is the insurance companies. Commissioners come and go, but the companies, made up disproportionately of middle-aged white males, remain. Up to now they have had the resources and power to control.

In the case of HR100, for example, by tallying Federal Election Commission figures, a WEAL intern learned that the insurance industry contributed almost $116,000 between January 1983 and January 1984 to members of the House Energy and Commerce Committee. Those members who had previously indicated they were against or (especially) undecided received the bulk of the money ($95,000). When the committee voted, it appeared that the insurance industry had bought the right to continue to discriminate in insurance on the basis of sex.

Finally, what can states do about the second problem—lack of coverage or the inadequacy of public programs? Minnesota was one of the first states to institute the Comprehensive Risk Sharing Pool for people who have been refused coverage because of some preexisting condition. This benefits those who are able to pay a relatively high premium, which is then subsidized by all insurance companies doing business in the state, and by the state to the extent that insurers are allowed a tax deduction for the losses they incur.

For those who are unable to pay, the state can make Medicaid eligibility as lenient as possible. Since the federal government gives states the option of whom to include in the "medically needy" category, i.e., eligibility standards, states can be as generous or stingy as they choose. If access to health care is a right, all citizens must be assured of some guaranteed level of care.

Ending sex discrimination in insurance will not by any means solve the problem of access to health care for women. It will not affect the two major reasons for the problem discussed at the beginning of this paper: lower overall economic status than men, and the fact that insurance is organized around certain types of employment and marital status. Nevertheless, it is important to achieve nondiscrimination in insurance in order to be consistent with a major policy goal in the society: ending gender discrimination. To allow discrimination in insurance to continue is to send a symbolic message to other spheres of society that we are not really serious about that goal.

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DRAFT

MEETING THE HEALTH CARE CRISIS

Health Care Subcommittee

January 25, 1989

NAM favors achieving cost control and improved health coverage through a phased reform approach in which government, private health care purchasers, and providers cooperate to achieve greater cost discipline. This should be done through the use of incentives rather than government controls. And we should use competition to find more economical ways to serve all Americans, rather than on efforts by providers or insurers to save money by shunning the poor, AIDS victims, and people with high health risks. To successfully tackle the health care crisis, we must take aggressive, but phased action. For NAM to maintain its leadership on this issue, we may need to chart new policy directions, some of which may reverse long held positions.

I. THE FUNDAMENTAL PROBLEMS WITH THE U.S. HEALTH CARE SYSTEM

As we approach the end of the 1980s, the U.S. health care system still has the same fundamental problem as in the early 1970s, when the great debate over health care--and a spate of remedial policy measures--began. It costs so much, yet leaves too many people vulnerable to inadequate health care coverage. This paradox--the coexistence of both soaring costs and troubling gaps--has been the hallmark of health care in the U.S. for the past two decades.

Our health system costs a half a trillion dollars a year, and now constitutes a little over 11 percent of GNP, compared to about six percent in the mid-1960s.

The sad fact is that the twin problems of cost and access are getting worse. After a brief respite, the cost of private health coverage has jumped sharply over the past year. Premium increases (or the equivalent cost of paying claims by self-insured employers) of 20 percent or more yearly are not uncommon, even in health plans where payors are tightening up on reimbursement and shifting some of the costs to consumers. Mr. Joseph Califano, a former Secretary of Health, Education, and Welfare, has suggested that the increase in premiums could hit 30 percent in 1989. Medicare outlays are now approaching $100 billion per year, or four times their 1977 level, even as Medicare has shifted some costs to employers and sharply increased premiums.

A decade ago, about 25 million Americans lacked any health insurance coverage. Recent estimates place the number of uninsured between 31 and 37 million people. About one-third of today's uninsured live in households with incomes below the poverty line. About 11 million children have no health insurance. Moreover, to be uninsured in America today is to be more vulnerable to being denied health care. Stated simply, the free care system is drying up. The ability of hospitals and doctors to load the cost of uncompensated care, or non-paying patients, into the charges of paying patients is greatly diminished in the more "bottom-line" approach to bill-paying that now governs the health care marketplace. The network of community health centers and neighborhood clinics is being shrunk by ongoing budget pressures.

The problems of sharply rising costs and inadequate access are inter-related. Higher costs are jeopardizing access, as third-party payors seek to control costs by screening out people with serious health problems, or making the cost of coverage prohibitive. Our society is encircling the "good risks" in good health plans, and too often throwing the "bad risks" overboard. This is no way to run a health care system.

What is so troubling about the continuation of cost increases that exceed the rate of inflation year after year is that both the private sector and government have taken major steps to control costs. Most large employers have introduced utilization review programs, increased cost-sharing by employees, redesigned their health plans to encourage care in less expensive settings, and created opportunities for employees to enroll in alternative health plans such as HMOs. The federal government has developed a new system for paying hospitals under Medicare that penalizes higher-cost providers and rewards cost-reducing measures. States have generally introduced prudent purchasing and case management in their Medicaid programs.

Yet, the current mix of regulatory and market forces is not working efficiently to provide high quality health care to the user. The health care system as presently organized and operating is seriously flawed, requiring fundamental reform.

II. THE UNDERLYING CAUSES

What forces are causing health care cost increases to exceed the rate of general inflation year after year? The answer is a complex mix of inefficiencies remaining in the system and the high cost of giving the American people what they seem to want--virtually unlimited health care, including a lot of care with marginal, or even dubious benefits at a very high price tag.

The Payment System

Despite many efforts to reform the system of paying for health care -- ranging from Medicare's instituting DRGs to private payers redesigning benefits to increase cost sharing by employees and making greater use of HMOs and PPOs -- the payment system remains a major cause of inefficiency and rising costs. The majority of payments are still based on cost or customary fees largely determined by providers. This is especially true for physicians. Governments underpay providers for Medicaid and, to a growing extent for Medicare -- resulting in cost shifting to private payers. Consumers still play a relatively small share for services giving them little incentive to use the services judiciously, leading to overutilization and higher costs. Moreover, few companies have yet adopted the more innovative and aggressive techniques of cost management being tried by a handful of leaders. The payment system was designed, or, more accurately, evolved when total health care spending as a share of GNP was little more than half of what it is now.

Quality of Care and the Value of Services

Some medical care is ineffective or even inappropriate and potentially injurious, largely because we lack a mechanism for defining just what "effective","appropriate," and "necessary" services are. Dr. John Wennberg's studies -- and those of others -- have revealed wide variations in the frequency with which certain common medical procedures are performed among small geographical areas in close proximity to each other, while finding little or no difference in health status. Employers as purchasers of these services have been questioning the prices of services without actually questioning the services themselves. Not surprisingly, they have had little success in controlling utilization of those services.

One fundamental cause is that we are probably providing some medical care that is ineffective--if not deleterious to health. We lack a clear mechanism for ascertaining definitively just what these questionable services are, and for communicating such knowledge widely to consumers and providers. The use of carefully-controlled and properly-evaluated clinical trials holds the potential to resolve this medical mystery, but we have not invested much in such endeavors.

Expensive New Technology

There is a veritable explosion of medical advances being made, and of costly technologies emerging from rapid scientific breakthroughs. Equipment with seven-figure price tags is purchased widely, only to be supplanted shortly by more sophisticated equipment -- as in the instance of CAT Scanners giving way to Nuclear Magnetic Resonators (NMR). But providers do not behave this way arbitrarily. They are responding to Americans' demand for and expectation of receiving the "best care that money will buy." Any effort to change this situation will raise serious bioethical issues in the U.S. that might not arise in other nations where expectations are different -- and lower.

Excess Capacity and Labor Intensive Production

Our health care delivery system is obviously overbuilt. The hospital industry, for example, has about one-third of its beds idle today. In addition, the industry is extremely labor intensive with rising wage costs driving up general costs. Ordinarily, pressure from buyers in a market economy would shrink and rationalize an over-built sector. But closing a hospital that is half-full, and distributing its patients across other hospitals with plenty of excess capacity, is not like closing an obsolete steel plant (and even that has been painful). In health care, there is a clear and understandable conflict between what is economically rational and what is socially preferred. Traveling 50 miles for health care is not acceptable to most people.

Malpractice Liability

Interacting with all of these factors is a medical malpractice system that, like the tort liability system in general, is badly in need of fundamental reform. The number of claims and the size of awards in the non-auto sector of our liability system have soared over the past decade. Premiums for malpractice insurance are now about one percent of health care costs, with the secondary costs of malpractice suits adding substantially to that figure. This has led to costly "defensive medicine," and in cases such as obstetrics, threatens access by encouraging doctors to abandon the field.

Demographics

Demographic factors have played a relatively small role in health cost increases so far, but this will be changing. The aging of our population in the years ahead will drive up the cost of Medicare, company-sponsored retiree health benefits, and long term care for the elderly.

III. GOALS/STRATEGY FOR CHANGE

Given agreement on the need for fundamental change in the health care payment and delivery systems, we need to set goals by which to measure the effects of that change -- and devise a strategy for reaching them. Our chosen goals are to reduce: (1) the rate of increase in health care costs; (2) the numbers of people and proportion of the population that lack health insurance coverage; and (3) the proportion of health care costs that are uncompensated. We have decided to reach these goals in stages by the year 2000, as shown in the following table:

		Year 2000 Goals		
	Current (1988)	1992	1996	2000
% Health Care Inflation	1.5 x CPI	1.2 x CPI	1.0 x CPI	1.0 x CPI
% Change in Total Health Care Spending	1.5 x GNP	1.3 x GNP	1.1 x GNP	1.0 x GNP
No. of Uninsured	37 million	28 million	16 million	5 million
% of Uninsured	16%	12%	7%	2%
% of Uncompensated Care	5%	4%	2%	1%

We include two measures of progress toward bringing spiralling health care costs under control -- the medical care component of the CPI, and total spending on health care. Our goals are to bring the rate of increase in medical care prices as measured by the CPI down to the same rate as prices in the economy generally, and to reduce the rate of increase in total spending down to the growth rate in nominal GNP.

Attainment of this latter goal would mean that health care spending would no longer consume an increasing share of total output (it is now 11.1% of GNP). We recognize that there are tradeoffs involved in setting such a goal. The rate of increase in health care spending cannot be reduced this much through gains in efficiency alone. Harder decisions about the allocation of resources to health care imply some "rationing" of services that cuts against the grain of consumer expectations of being entitled to whatever care is "necesary."

To gain control of spending -- and costs, we have to gain greater control over the utilization of services as well as slowing the rise of prices. Allowing for advances in medical technology and the increasing impact of an aging population in the future would require a higher rate of increase in total spending; otherwise the pace of technological growth would be slowed. The point is that we cannot have it both ways: there will be some "costs" to cost control itself.

These "costs" will be easier to bear, however, if private purchasers develop effective means to measure the quality of services provided, in order to make defensible decisions about the "value" of what they are getting for their health care dollar. Purchasers must be able to discuss cost/quality issues on even terms with providers, if we are going to move beyond the point of merely haggling over price to actually start controlling the use of services. Our goal in this area cannot be stated in quantitative terms, but employers need three kinds of information to make these kinds of judgments:

(1) Measures of effectiveness -- whether treatment improves the patient's condition (outcome);

(2) Measures of appropriateness -- whether the intensity of treatment is consistent with the severity of the condition;

(3) Measures of efficiency -- whether the cost of treatment is consistent with the outcome.

Quality and value will never be as simple to measure as cost, but we must improve employers' abilities to make these judgements if they are to gain control of cost.

Only a universal coverage scheme, such as national health insurance, would immediately cover all the uninsured, and that is not an option in the American political and fiscal environment. All other approaches advocated would reduce the number of uninsured, but not eliminate them entirely. Even the Kennedy-Waxman bill would cover only two-thirds of the uninsured -- those who are working or in the household of a worker.

The NAM is clearly on record in oppostion to the sweeping mandates that Kennedy-Waxman would impose on employers. Our goals for reducing the number of uninsured (and, consequently, the amount of uncompensated care) are incremental. By the year 2000, we would seek to reduce the number of uninsured of 37 million to 5 million, or 16 percent to 2 percent of the population. This would be a mangeable size for what is now a huge problem and avoids the serious drawbacks associated with the more centralized approaches that have been advocated. It will be much easier to obtain this goal as we achieve the primary one of getting costs under control.

U.S. Health Care Costs vs Other Industrialized Nations

The U.S. spends more on health care as a proportion of its total resources than any other industrialized nation. For example, in 1984, the U.S. spent 10.7 percent of its gross domestic product on health care. The only other countries to spend over 9 percent were Sweden (9.4 percent) and France (9.1 percent). The mean share of GDP devoted to health care among 21 OECD countries reporting data was 7.5 percent, or 30 percent below the U.S. figure. Canada spent 8.4 percent of GDP on health, while in the U.K., the corresponding figure was 5.9 percent. In 1960, Canada and the U.S. spent about the same proportion of GDP on health (5.5 and 5.3 percent, respectively).

Of course, a rising proportion of national product devoted to health care does not, by itself, suggest that a country is spending too much on health care. If the increase in relative spending for health care translates into a greater rate of growth in output leading to a healthier work force, more resources would be available for the purchase of all goods and services, including health care. Thus, if health outlays enhance productivity, we do not have a zero sum game in which more for health means less for something else.

In addition, if spending more on health can be shown to result in better health outcomes, it may reflect a conscious choice by a society to shift resources in the direction of health to relieve suffering and to lengthen life.

What has brought the issue of health costs into high relief is the nagging and growing feeling that we are not getting more for our money, either in terms of increased productivity or better health. In part this occurs because a very large share of the increased spending--and of the increase in life expectancy that we have experienced--has been concentrated among the elderly.

While increasing the life expectancy of the elderly is a good development, it is not going to yield increases in productivity and GNP. Moreover, life expectancy in the U.S. is no higher than in other countries that spend far less than we do on health care. The case for higher U.S. costs would seem to rest on the assumption of more ready access to care in the U.S., and on contentions that quality of care is superior here. But these assertions are difficult to prove, particularly when one of seven Americans lacks health coverage altogether. Not all "extra" spending on health care in the U.S. is "waste," though; it is generally agreed that citizens of Britain give up something in access to the system for non-emergency procedures compared even with medically indigent Americans.

Thus, we are drawn toward asking the tough questions about whether physicians and other providers of health services are paid more than is necessary to call forth an adequate supply of high quality services and whether our health care payment system leads to unnecessary tests, procedures, hospital admissions, etc.

In any event, the high cost of health care in the U.S., relative to other countries, is hampering the competitive position of U.S. firms in an increasingly global economy.

IV. BROAD OPTIONS FOR REFORM

Reform of the health care system could take a number of directions depending on the mix of government intervention and/or private control we choose. Members of Congress, health policy experts and business leaders have suggested a range of options including a government mandate on all employers to provide health insurance to workers; taxing employers who do not provide insurance; a universal national health plan; a pro-competition plan developed on a national basis. A phased, incremental approach that combines public sector reforms with private sector initiatives will be the best way to achieve the fundamental, long-term restructing of the system that is needed.

Mandated Employer-Provided Health Benefits

A mandated benefits approach requires employers to offer health insurance to persons working at least 17.5 hours per week (Senator Kennedy D-MA). Employers would be required to offer a benefit package equal in value to a government-specified set of benefits, and to contribute at least 80 percent of the premium cost for both workers and dependents. A similar mandated benefits approach would tax employers who do not provide a government-specified level of health benefits to workers and dependents (Rep. Stark D-CA; Massachusetts plan).

This approach would solve about two-thirds of the uninsured problem without imposing a government presence that would accompany a national health plan. In addition, it would achieve certain social policy goals at little or no added cost to government.

This last advantage, of course, can be seen as a disadvantage, from the perspective of the private sector. The government solves its problem under a mandated benefits approach by shifting the burden to the business community. An additional serious concern is the threat to job prospects, particularly for less skilled young people, resulting from the higher cost of employing workers as a result of mandated health coverage.

Canadian Model Health Insurance System

A centralized, public sector health plan might follow either the Canadian or British model. The National Health Service in Britain is financed almost entirely from public funds. General practitioners contract with localities while hospital-based physicians and many specialists are salaried. The national government sets a fixed budget, adjusted from the previous year for inflation and perhaps, for some increment of real growth. Such a heavily centralized organization of health care could not be imposed on the medical "culture" of the U.S. without massive resistance from providers and consumers alike, and is not a feasible option.

The Canadian model is quite different, centralizing the financing but not the delivery of care; as such, it would not be nearly so alien. Health care is purchased by the provincial governments, which negotiate fees with local medical associations and hospitals; financing comes from general revenues and, in several provinces, from premium contributions by beneficiaries and from payroll taxes on employers. There is a private insurance market as well, for items not covered by the national system. The latter plans are often bargained between employers and their unions.

The provincial governments are what economists call "monopsonistic" purchasers of health care, i.e., effectively the only ones. As such, they have considerably more "market" power than any providers, with the ability to keep exerting substantial downward pressure on prices. While such power may keep a "lid" on prices -- at least for a while, it does not necessarily control costs in the longer run -- as we are beginning to see in Canada, where costs are starting to rise more rapidly and access problems of the British variety (e.g. long waits for surgery) are now appearing.

Another problem with trying to administer a Canadian-style system in the U.S. is the difference in the size and number of "administrative units." Canada has a dozen or so provinces and a tenth or less of our population. We have 50 states, and one state alone -- California -- has more people than all of Canada. The Medicaid program could be offered as a model, but the states are hardly prepared to start dealing with ten times as many eligibles -- nor, with a few exceptions, are they prepared to bargain with providers.

The Canadian system admittedly offers comprehensive coverage that leaves no uninsured. Its other cited advantage of global budgeting to control costs is only an apparent advantage. Private and public purchasers in the U.S. can equip themselves to exercise market power as well, and under a decentralized system that is less likely to stifle innovation and is better constituted to satisfy consumers' choices. The case for any such centralization of health care needs to be weighed very carefully against that for a strategy favoring decision-making in a competitive marketplace.

National Pro-Competition Plans
Alain Enthoven, Professor of Public and Private Management at Stanford University, has created the Consumer Choice Health Plan that would replace the current open-ended, employer-financed private health insurance system and the Medicaid program with universal tax credits (refundable for lower-income individuals) for the purchase of health plans. Medicare would be kept, but changed into a voucher program. Enthoven's scheme would provide universal coverage, but leave market incentives and competitive forces to control costs instead of imposing a national regulatory regime.

The problem is that individual consumers are neither knowledgeable enough nor economically powerful enough to challenge providers' control of the health care system. Only private employers or government acting as purchaser are constituted to do this. Tax credits may be a useful financing device, and consumer choice is a worthy objective. These can both be part of a competitive, pluralistic system, while maintaining an employer-based insurance mechanism that keeps business involved as a countervailing force to providers.

Uwe Reinhardt, Professor of Political Economy at Princeton University, has suggested the Fail-Safe system that would create a basic catastrophic insurance program for all citizens, and charge participants a progressively rising tax on their incomes. Those with adequate private coverage -- presumably through their employers -- would be excused from the tax, as would people below the proverty line. In effect, individuals rather than employers would be mandated to have health insurance, and financing would be available to make it affordable for all Reinhardt suggests that the Fail-Safe program be administered through the states, like Medicaid.

Employers would have strong incentives to "dump" their workers into the new program. The only check on this would be pressure from the workers themselves by creating a steeply progressive income tax driving workers to demand coverage from their employers. This puts workers in a potentially untenable position, and raises a new issue while trying to resolve an old one.

National Leadership Commission on Health Care Proposal

The National Leadership Commission on Health Care, co-chaired by former Congressman Paul G. Rogers, was formed about a year ago to examine our health care system and make recommendations on access, quality and cost. Consisting of providers, insurers, labor, and business members, the Commission is expected to issue its report in January. While no preliminary documents have been issued to date, indications are that an employer tax is being discussed for firms not providing health benefits. Certainly, access must be expanded, however, the Commission should carefully consider the economic and broad benefit impact of this approach. At the same time, we intend to work with the Commission to address the essential quality and cost issues now seriously affecting our health care system.

Competitive Cost Management System

A competitive, pluralistic health care system is our chosen option for managing health care costs and quality while improving access for those who lack it now. Elements of such a system already exist, but concerted and sustained efforts by business and government are necessry to bring them together into a functioning "system" that will achieve our goals while preserving the values associated with pluralism -- choice, diversity, and innovation.

The key for business purchasers of health care -- and for government -- is to gain some control of the system from providers. This requires that they develop the ability to define the "product" -- health care -- that they are buying, and to judge its quality. Only in this way can they make the necessary tradeoffs between costs and "quality" required to control their employees' use of services.

This approach to purchasing, focusing first on what is being purchased and then on its price, is being developed by a few leaders around the country. In Pennsylvania, it is being implemented in several parts of the state by Walter McClure's Center for Policy Studies, under the name of the "Buy Right" approach. The essence of Buy Right is developing the means to compare the performance of providers on the basis of quality and costs, and then rewarding cost-effective, high quality providers by sending them more patients. This is done by giving consumers information on those providers and financial incentives to choose the most efficient and effective ones.

Honeywell, Inc. is pursuing a similar strategy in Minneapolis, seeking the data from Blue Cross to make such judgments, and the Midwest Business Group on Health, based in Chicago, is working to develop usable measures of quality for its hundred or so corporate members. Public policy can aid this private sector effort to get control of costs by requiring provider-specific data to be made available to the public. Pennsylvania, by doing so, has helped make it possible for the Buy Right approach to be implemented. Iowa and a few other states have similar laws, but all states should enact such measures as one of the most important actions they can take to promote the competitive system.

Public programs can pursue this strategy as well, and even have quality assessment mechanisms (Professional Review Organization -- PRO's) in place to build on. Some states have already shown initiative by experimenting with new approaches to serving Medicaid recipients. Both Medicaid and Medicare should start identifying and directing recipients to "preferred" providers, just as some private employers are doing. Their enormous purchasing power could speed the movement to a more efficient health care system, if they would use it as part of a Buy Right strategy. A more cost-effective system will be able to serve more people, expanding access to more of the uninsured through Medicaid.

At the same time, small employers can group their workers together in larger risk pools to pursue the same strategy. A good example of this model is the Council of Smaller Enterprises, an affiliate of the Greater Cleveland Growth Association in Ohio.

Such an approach is, by its nature, incremental -- or perhaps it should be called progressive. The system will not be changed overnight, but a sweeping mandate in itself does nothing to change the system other than make it larger. Many specific policy reforms can speed the progress of this effort to build a competitive, efficient system that will better control costs. Some of these are described in the next section.

V. A PHASED, INCREMENTAL APPROACH

An incremental set of policies would combine a new approach to financing health care for the poor (either through Medicaid expansion or new tax credits) with a series of public/private measures designed to expand the population in the private group health insurance system. The latter measures include incentives for the formation of state-wide risk pools, tax incentives for the self-employed to purchase health insurance, incentives for companies and employees to purchase long-term care insurance or pre-fund long-term care benefits as well as incentives for companies to pre-fund acute-care medical benefits for retired workers.

A phased incremental approach is recommended at this juncture. Such an approach should be distinguished from the piecemeal, fragmentary approach that has characterized our health policy to date. We favor the development of a long-range vision for a better health care system, one that solves the key problems of cost and access.

The incremental steps we suggest are designed to move us toward our long-range objectives--that is, our recommendations are not selected in a random fashion. The phasing of these steps reflects both budget realities and learning curves--we can make mid-course corrections as we discover problems with our incremental actions.

Our vision for health care is a pluralistic system in which most Americans continue to receive health coverage through the workplace, with benefit levels, contributions by workers and firms, and patterns of care determined by labor and management subject to minimal government interference. A fair and complete safety net would be maintained by government to assure that people are not denied care because they are poor or "high-risk." Government would also foster open and competitive markets.

Medicaid "Buy-in". This reform would extend Medicaid to more of the poor, allowing individuals to maintain coverage as earnings rise, with declining government contributions. Beginning with coverage for children five years of age and under, older children and adults could be phased in later. Households with incomes below the poverty line could make a nominal 10 percent contribution to the premium, while those in the near-poor range would pay a higher share. Those with incomes above 130 to 140 percent of poverty would receive no subsidy, but between this level and some higher range (e.g., 175 percent of poverty) individuals could buy into Medicaid by paying the full premium. This is preferable to buying individual coverage. For employed low-income workers, employers not offering coverage could be required to contribute some percentage of the premium. Bringing all children below the poverty line into Medicaid on this basis would cost about $1.5 to $2.0 billion per year.

Medicaid Management Improvements. Medicaid should be reformed to build in more prudent purchasing and more incentives for consumers and providers to engage in cost-conscious behavior. This includes a greater emphasis on guiding Medicaid beneficiaries to primary care doctors, such as general practitioners or pediatricians. Obtained early, primary and preventive health care can avoid subsequent more costly and unneccessary care. This strategy also requires financial incentives in the form of adequate reimbursement for providers to participate in Medicaid, along with arrangements under which such "case managers" share the risk of excessive costs with the government.

Medicare. Medicare should continue to refine the prospective payment system for paying hospitals (DRGs) in order to smoothe out inequities, including properly updating the system for inflation and changing technology. It is time to move toward a new method of paying doctors under Medicare where payment does not automatically rise with prevailing fees in the community. The major options for reform include substituting a fee schedule for the current practice based on customary and prevailing fees; a DRG-like system that bases reimbursement on a specific diagnosis and a spell of illness, rather than pricing out each service separately; and a "capitation" system under which doctors receive a fixed amount of money to provide care for a group of patients over a year's time. Medicare should continue to create incentives for patients to participate in managed care systems, broadening the scope of available choices beyond Health Maintenance Organizations (HMOs).

Long Term Care. Moving toward an expensive, front-end loaded government entitlement program for long term care would be a mistake. Yet, the current system--in which half of total outlays are paid for out-of-pocket and about half through Medicaid after a family is impoverished--must be improved. To spur the development of the private market for long-term care insurance, the federal government should create a more favorable tax climate for such insurance. Both federal and state governments should experiment with new ways to subsidize the premiums, deductibles, and copayments associated with long-term care insurance for people who cannot afford these costs.

Financing long-term care is another area where a time-phased approach could be useful. The first step might entail clarifying the tax treatment of contributions to long-term care insurance. The second phase might involve limited government subsidies for the out-of-pocket costs of such private insurance for low-income persons. A third phase could entail a government "stop-loss" or catastrophic coverage for long-term care under the Medicare program. Under this approach, Medicare coverage for long-term care expenses would kick-in after patients and their families had spent a certain amount of money on such services (or had paid for them out-of-pocket over a specified time period such as two years).

Tax incentives. Tax incentives should be available for the self-employed to purchase health insurance. Currently, self-employed people cannot take advantage of the tax preference accorded to employees, who can exclude the full amount of their employer's contribution to health insurance. In the last Congress, legislation on this topic was considered, but never acted upon. Tax incentives could also be used to help very small or new firms. This might entail tax credits to employers in a start-up phase designed to defray some of the initial costs of implementing and administering employer health plans. These credits could be phased-out as the firm becomes more economically viable.

Risk Pools. We should extend risk-pooling arrangements that enable groups of firms and workers to broaden the insurance base and obtain the more favorable underwriting terms and lower administrative costs available to larger groups. Such efforts can build on existing arrangements such as Multi-Employer Trusts and risk pools at the state level. In some cases, government subsidies may be appropriate to defray a portion of the costs. For example, in Illinois, some state revenues are used to contribute to the cost of serving high-risk patients with pre-existing health conditions in a state-wide pool. Such subsidies can keep the out-of-pocket costs for insurance coverage facing such patients from being prohibitive. In designing such arrangements, we should not discourage employers who might otherwise seek to provide insurance through conventional means.

Local Employer Coalitions. Coalitions of employers organized to improve health cost management, and to pool and review claims data have been organized in many communities. Good examples of such groups are the

Chicago-based Mid-West Business Group on Health, with membership covering firms in ten states, and the Health Policy Corporation of Iowa. The business community should expand such efforts and broaden their scope to include the important question of indigent health care.

Regulation. Regulatory barriers that block certain service providers from competing in health care markets should be relaxed. For example, hospital staffing privileges should be offered to a wide range of health care workers, including such groups as nurse practitioners. Licensure requirements should not discriminate against one type of service provider to protect the economic interest of another type. Allowing a wide range of groups to compete does not mean that states should mandate that all insurers must include such services in their benefits package. In general, government ought to engage in less economic regulation of health care, while paying more attention to the quality of services. Accounting standards requiring firms to reflect the value of future obligations to pay retiree health benefits on their balance sheets should be implemented on a phased-in basis to facilitate a smooth adjustment. The new Financial Accounting Standards Board (FASB) requirements should accommodate the needs of employers to avoid wrenching one-time changes in their balance sheets. Government "anti-discrimination" rulings governing health insurance (e.g., Section 89 regulations) should be carefully reviewed to assure that they do not stifle incentives for firms to offer a choice of health plans to their employees.

VI. NAM POSITION

The policy reforms discussed in the last section are consonant with established current NAM policy which is described below.

Mandated Health Benefits

The NAM believes that government interference in the system of employer-provided health insurance, which well serves the majority of Americans, would be a mistake. Thus, we oppose flat government mandates that would require all employers to offer coverage that meets government-specified benefit levels.

Instead, NAM has recommended the establishement of a Medicaid buy-in for low-income workers; elimination of legal barriers to group purchasing of insurance; development of basic low-cost catastrophic plans; providing an ERISA exemption of state benefit mandates; tax incentives for the self-employed to purchase insurance; tax credits for selected firms to provide insurance; and state insurance pooling arrangements with general revenue financing.

Retiree Health Benefits

In a similar vein, NAM believes that employer decisions to provide retiree health benefits should be voluntary, and that employers should be provided with incentives to pre-fund retiree health benefits. The federal government should meet its budgetary pressures under Medicare not by shifting the cost of its obligations to business, but rather through fundamental structural reforms, such as developing a more efficient way to pay doctors, encouraging managed care, and refining the

DRG system for paying hospitals.

Long Term Care

An aging population, greater longevity, and increased participation in the labor force by women -- the traditional caregivers of the elderly -- are combining to increase demand for long term care services. To address this issue, NAM recommends: (1) encouraging private insurers to develop affordable long term care plans; (2) giving employers tax incentives to offer such policies, at least as an option, to their workers under group insurance plans to reduce the cost; and (3) allowing individuals to make tax-favored transfers from life insurance or annuity contracts, IRAs, and defined contribution plans to purchase long term care insurance.

Tax Treatment of Health Benefits

Tax policy in the health care area should have its major focus on containing health care costs and not on raising revenue. Changing the tax exempt status of employee health benefits would be inequitable because of variations in medical costs relative to geographical locations, age group, and health status. Proposals have been made to tax a portion of the premium paid by employers for health insurance provided to their workers. The exclusion of all such employer-paid premiums from taxation amounts to a significant amount of forgone revenues that could be used, for example, to help finance expanded coverage for the uninsured. But taxing these premiums would open the door to possible future taxation of employee benefits more generally, a trend endangering the well-being of American workers and their families.

VII. NEXT STEPS FOR NAM

In order to build momentum in our efforts to improve the health care system and be prepared for upcoming legislative debates, we recommend the following additional steps:

1. Develop a white paper on the scope of the problem and solutions for addressing it, along the lines of this paper;
2. This could be followed by a separate paper summarizing what firms can do to reduce health care costs;
3. Conduct a member survey on the issues and preferred options;
4. Solicit letters from NAM members on the scope of the cost problem for use in lobbying and public relations efforts;
5. Develop legislation to address cost and access problems that is sensitive to NAM's varied membership;
6. Work with selected members of Congress and the administration in support of practical legislation;
7. Spearhead coalition of employers and employer trade associations to address the health care crisis;
8. Develop a comprehensive public relations effort.

For further information
contact Sharon Canner,
NAM at (202) 637-3124.

LONG-TERM HEALTH CARE NEEDS

TUESDAY, FEBRUARY 14, 1989

U.S. Senate,
Committee on the Budget,
Grand Forks, ND.

The committee met, pursuant to notice, at 9:30 a.m., at the Civic Auditorium, 615 1st Avenue North, Grand Forks, ND, Hon. Kent Conrad, presiding.

Present: Senator Conrad.

Staff present: Gorman King, Counsel and Legislative Assistant.

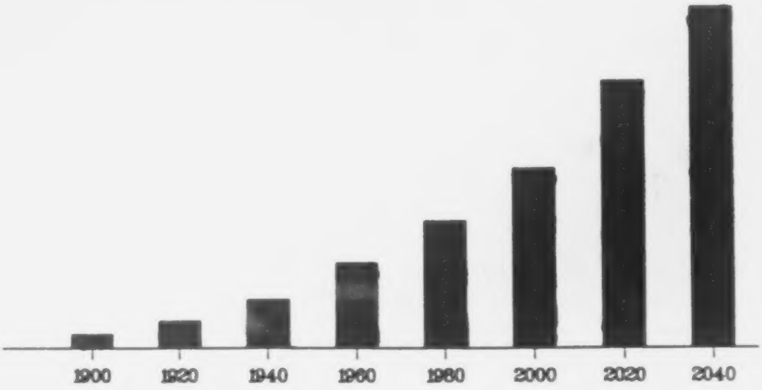
OPENING STATEMENT OF SENATOR CONRAD

Senator Conrad. First I want to welcome you all here this morning to the second in a series of hearings before the Senate Budget Committee on the issue of health. Yesterday in Fargo we heard of the problems or soaring health care costs and the problem of the uninsured and underinsured. Yesterday we learned that if current projections hold, health care costs in this country will double by 1995. They will triple by the year 2000 and in the year 2000 we will be spending $5500 for health care for every man, woman, and child in this country every year. Now clearly that's not something we can afford.

Already we are spending about 11 percent of our gross national product on health care. Much more than any of the other industrialized countries of the world. And at the same time we have those soaring health costs, we are also confronted with the problem of unmet needs because as we also learned yesterday we have 37 million people in this country with no health insurance. And in this State we have between 70 and 80,000 with no health insurance. Nationally about a third of those without insurance are children. And we heard cases yesterday of mothers being concerned and being unable to get treatment for their children when illness struck because they didn't have sufficient funds to pay a medical premium.

Today the focus in this hearing is on long-term care, nursing home care. That is for our elderly, the elderly parts of our population the overriding problem that they face. It is a growing problem. As the first chart shows our population is an aging population. This chart shows the number of people aged 65 and older and millions of people from 1900 to the year 2040 and you can see in 1980 we had 24 million people in this category. In the year 2040 we will have 65 million people in this category. So we're experiencing explosive growth in that part of our population which is 65 and over.

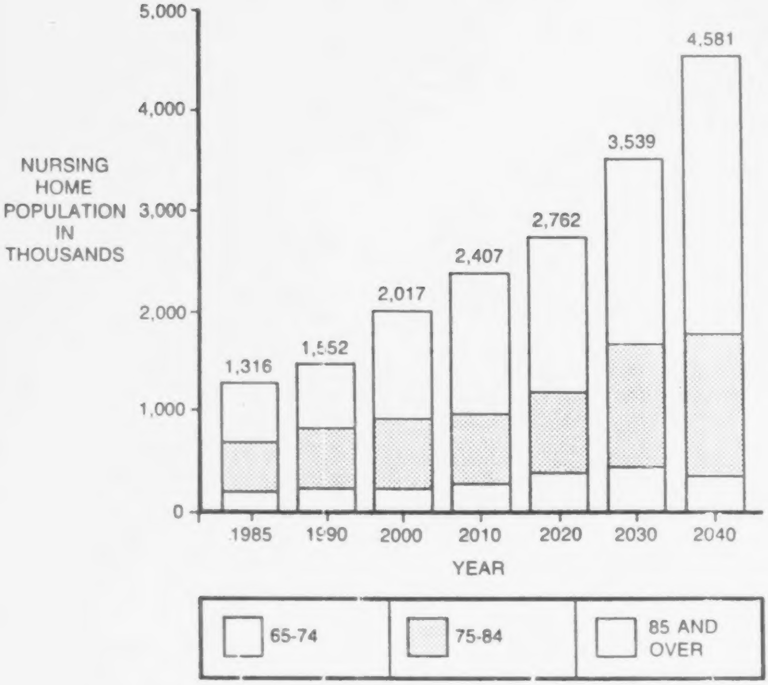
Aging of the U.S. population: number of people age 65 and older, 1900 – 2040 (in millions)



Source: U.S. Bureau of the Census

The next chart we have shows the projections of the nursing home population 65 years and older from 1985 to the year 2040 and this is expressed in thousands and you can see that we're talking about in 1985 having a million 316,000 going in the year 2040 up to four million almost 600,000. You can see they're more than tripling of those in nursing homes and if we add in those who require long-term care but won't be in nursing homes, we're looking at a figure in the year 2040 of another 14 million, so a total of over 18 million people needing long-term care in the year 2040.

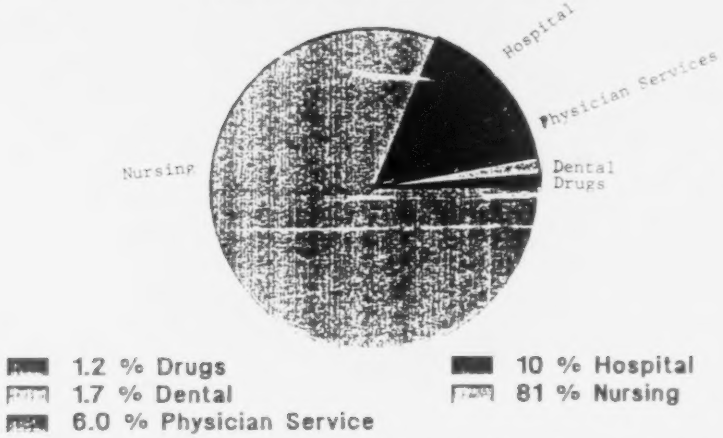
PROJECTIONS OF THE NURSING HOME POPULATION
65 YEARS AND OLDER BY AGE GROUP:
1985-2040



SOURCE: U.S. Administration on Aging. Unpublished projections based on nursing home utilization rates from the 1985 National Nursing Home Survey and population projections from the U.S. Bureau of the Census.

Let's show the next chart that shows what the out-of-pocket expenses for the elderly are. These are expenses of over $2,000 a year and you can see very quickly where the lion's share of the cost is. 81 percent of the cost is for nursing home care. 81 percent of the out-of-pocket expenses for our elderly population is nursing home care.

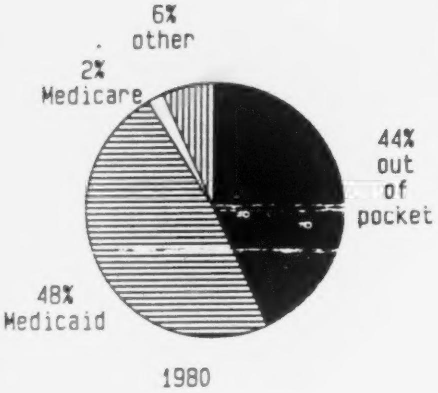
ELDERLY OUT-OF-POCKET EXPENSES
OVER $2000 / YEAR



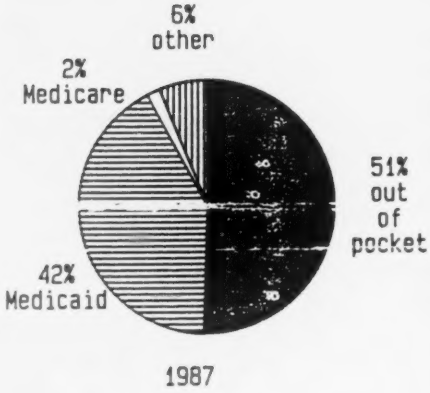
J. Gabel and T. Rice, 'Protecting the Elderly Against High Health Care Costs,' Health Affairs, 5 (Fall 1986), p.12.

Why don't we show the next chart. The question becomes where is this being paid for? And this chart shows nursing home costs by source of payment in 1980 you can see then that medicaid was paying about 48 percent, out-of-pocket 44 percent, medicare only 2 percent. 1987 you can see how the bearing of the cost has shifted. Medicare still only 2 percent, medicaid down to 42 percent, out-of-pocket expenses, that is, right directly from consumers 51 percent.

NURSING HOME COSTS BY
SOURCE OF PAYMENT
1980



NURSING HOME COSTS BY
SOURCE OF PAYMENT
1987

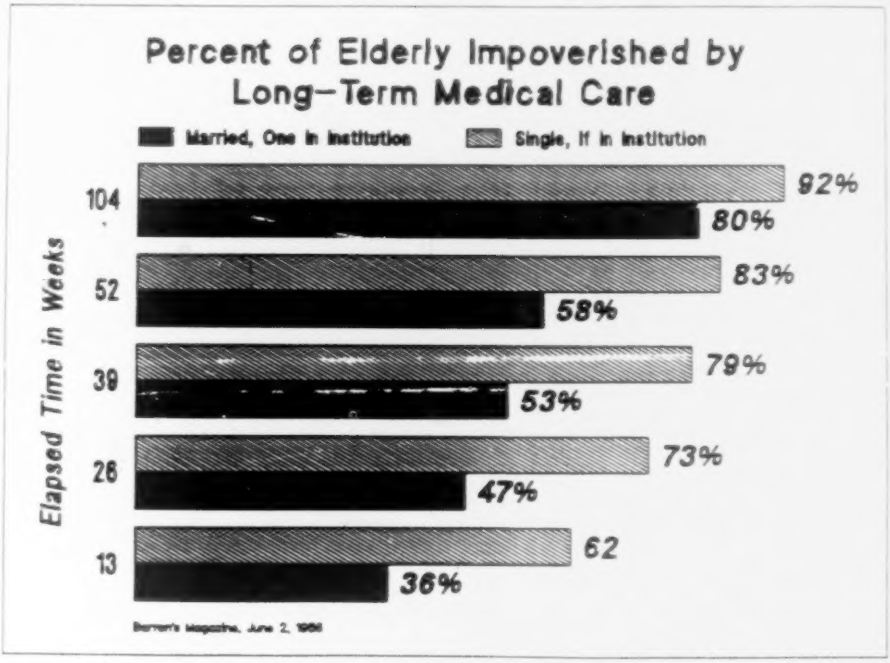


Source: Health Care Financing Administration
Office of the Actuary

Note: Percents may not add to 100 due to rounding.

So the story that we want to get across here is the cost of nursing home care is only taken care of from a government program less than half of the total cost. And medicaid's portion is declining and declining rather sharply. In addition, of course, medicaid is only for people who have the least funds. Middle class and upper middle class are paying for nursing home care out of their own pocket.

The most, I think, stunning message that we have today is what happens to folks who need nursing home care. This chart shows the percent of elderly who are impoverished by long-term medical care or nursing home care. On this part of the graph we show, weeks, 13 weeks, 26 weeks, 39, 52, 104 weeks, number of weeks in nursing home care. The red bar is for a married couple with one person in an institution. The blue bars are for single people who are in an institution.



Percent of Elderly Impoverished by Long–Term Medical Care

Barron's Magazine, June 2, 1986

And what this chart tells you is after only 13 weeks a single person, a single person in an institution is impoverished 62 percent of them are impoverished after only 13 weeks. Now let me say that again. That's a fairly staggering statistic. If there's only one person in the household and they're institutionalized, 62 percent of them are impoverished after only 13 weeks. You can see for married couples after 26 weeks, if one of them is institutionalized, they're impoverished. 47 percent of them are impoverished after only 26 weeks. And you can see at the top of the chart for singles 92 percent are impoverished after 104 weeks. 80 percent of married with one in an institution are impoverished after 104 weeks. Now that is a problem. That is a societal problem of enormous dimension.

I can remember my first involvement in this issue was when a neighbor in the apartment building I lived in in Bismarck came to me. She's about 80 years old and she said, Kent, she was crying, I have a terrible problem. I talked to my attorney today and he said the only way we can avoid selling the last quarter of our land is if I divorce my husband who is in the nursing home and we have been married for over 50 years. And she said to me, I can't do that. And yet if I don't do it, we're selling the home quarter and our children will never have a chance to experience the place that we grew up and made a life and a family.

Now that is a set of choices that nobody should have to face in our society. To divorce your spouse of 50 years in order to avoid impoverishment, that should not be the choices facing people in our society, but all too often that is what is facing people in our society. That is the subject that we're here to address today. The problems of long-term care, how we're going to pay for this in the future, how we're going to deal with this as a society.

[The prepared statement of Senator Conrad follows:]

SENATE BUDGET COMMITTEE HEARING

CRISIS IN RURAL HEALTH CARE:
LONG TERM CARE FOR THE ELDERLY

OPENING REMARKS OF SENATOR KENT CONRAD

Welcome to the second of the three Senate Budget Committee hearings I am holding in North Dakota. Yesterday in Fargo we explored the rising cost of health care and the problems of the uninsured in North Dakota and around the country. Today's hearing will focus on one particular area where costs are extremely high and for which the vast majority of North Dakotans and Americans are uninsured or underinsured: long term care.

While the Medicare program protects the elderly from the significant costs that can arise from an acute illness, the vast majority of seniors have no protection against the devastating costs of long term care for a chronic illness. And millions of seniors need long term care: it is estimated that upon reaching age 65, seniors have at least a 43% chance of entering a nursing home at some point during the rest of their lives. As every one of the millions of Americans whose spouse, siblings, or parents have required prolonged nursing home care knows, even a short nursing home stay can be financially ruinous. This is unacceptable; we must find ways of easing the financial and emotional burdens of providing long term care for the elderly.

Because the need for and the costs of providing long term care -- the array of medical, social, personal and support services needed by the functionally limited or disabled elderly -- is expected to grow rapidly over the next several decades, the financing and delivery of long term care is one of the most important health care policy issues facing the Congress today.

There are several reasons that the need for long term care is expected to grow. First, demographics are changing: the United States is growing older. Currently, almost 12% of the population is over 65; by 2020 -- as the baby boom generation ages -- the 65+ population is expected to more than double. By 2030 one out of every five Americans will be elderly.

This trend will be exaggerated by the growth of the "old old" population. Those over age 85 are the group most likely to need long term care services; they are also the fastest growing segment of the population. In 1900 there were 123,000 people age 85 or over, today there are 2.8 million, by the beginning of the next century we can expect 4.6 million, and when the baby boom generation reaches age 85 -- around 2050 -- this group may number 15 million according to the latest US Census Bureau projections.

In general, the elderly comprise a greater percentage of rural populations than of the United States as a whole -- over one fourth of the rural population is elderly. However, in North Dakota the elderly account for about 12% of the state population. Unlike the country as a whole, in North Dakota the elderly population is not expected to grow -- and may actually decline. These general statistics obscure some interesting facts, though. One is that in North Dakota, as in the country as a whole, the elderly live disproportionately in rural area. A majority of the elderly live in rural areas of the state, and communities with populations between 1000 and 2500 have the highest concentration of elderly at 21%. And, again like the country as a whole, North Dakota's over 85 population is expected to grow significantly.

As the numbers of elderly increase, the numbers of elderly needing long term care will also increase. And the years that are being added to our life expectancy are disproportionately unhealthy ones, requiring varying degrees of assistance and care. Today approximately 6.6 million elderly -- or more than one fifth of the over 65 population

-- need some form of long term care; 1.4 million are nursing home residents while 5.2 million are receiving home based care. According to a recent nationwide poll, 60% of the respondents had had some experience in their own families or through close personal friends with the need for long term care. In 50 years demographics alone suggest that there will be 4.4 million nursing home residents and 14.4 million elderly receiving home care. For the over 85 population the need for long term care is especially severe. While under 5% of the total elderly population is institutionalized, 23% of the over 85 population resides in nursing homes.

North Dakota is certainly not an exception to these statistics. Over 6500 North Dakotans are nursing home residents. The state ranks second in the percentage of its elderly population in nursing homes and eleventh for the number of nursing home beds per capita elderly population. For the over 85 population, the figure is especially dramatic: 37% of North Dakota's over 85 population resides in nursing homes.

And nursing home care is expensive. The cost of a year in a nursing home can be as high as $50,000 a year, with the average currently around $25,000. In North Dakota, a recent Health Department study found that costs range from $15,000 to $30,000 a year, with the average around $23,000. In the US as a whole, expenditures on long term care have grown enormously, reaching $45 billion in FY85. Of this $21.4 billion was from private sources. In fact, nursing home costs are the major catastrophic health care expense for older Americans, accounting for over 80% of the expenses incurred by those with very high (over $2,000 per year) out-of-pocket costs for health care. And total nursing home costs are expected to reach $129 billion a year by 2000.

While it is clear from this discussion that there is a dramatic need for long term care services and that this need will grow extremely rapidly over the next several decades, the federal government currently offers only limited coverage of long term care. Medicaid is the primary source of government spending on long term care -- accounting for approximately 89% of all public expenditures for nursing homes. In North Dakota, for example, Medicaid currently pays for over half of the nursing home costs incurred on the state; this is significantly above the national average of 42%. Nationally, long term care has grown from 40% of the Medicaid budget 15 years ago to almost 70% today.

However, the Medicaid program was created as a program to provide medical assistance for low-income persons, and most older Americans are not eligible for Medicaid. Consequently, before they can qualify for Medicaid the institutionalized elderly must impoverish themselves. According to the Department of Health and Human Services, about one half of the persons currently receiving Medicaid coverage for their nursing home care became eligible for Medicaid after they entered the home. And because the majority of most elderly couples' income is attributed to the husband, if he enters a nursing home he must spend down until this income reaches the Medicaid level, often leaving his wife with only a minimal income level. (The income levels for the community spouse will be improved slightly when the spousal impoverishment provision of the Medicare Catastrophic Coverage Act of 1988 takes effect on September 30, 1989, but the spend down requirement will remain unchanged.)

The second major federal health care program for the elderly is Medicare. While many persons believe Medicare coverage includes long term care, in most cases it does not. Medicare accounts for less than 2% of total spending for long term care, because it is focussed on acute rather than chronic care. Medicare covers nursing home visits only where a need for skilled nursing care can be demonstrated. Similarly, Medicare coverage of home health care is limited. Although Medicare payments for home health have been one of the fastest growing portions of the Medicare budget, it still accounts for only a tiny portion of total program outlays. While the Catastrophic Health Bill expanded home health coverage, it does not change the focus from rehabilitation after an acute illness. The only new long term care benefit in this legislation is the respite care provision which covers up to 80 hours per year of in-home benefits for chronically dependent beneficiaries as a respite for the regular caregiver.

Despite enormous increases in federal spending on long term care, out-of-pocket payments account for over half of nursing home costs. And informal caregiving remains the source of the vast majority of home health care. In fact, despite the popular belief that fewer people are willing to provide care for a chronically ill or dependent relative, relatives provide about 80% of informal care, and for every elderly person in a nursing home, there are at least two with as severe a disability living in the community.

Given the limitations on government coverage of long term care, it is not surprising that the majority of nursing home spending is financed out-of-pocket. Yet the vast majority of the elderly are unable to afford these out-of-pocket expenses and are uninsured against this risk. The median family income for the elderly is about $20,000, significantly less than the average cost of a year in a nursing home. And the over 85 population -- which is most likely to be institutionalized -- also has much lower incomes than the younger aged. In North Dakota, the average per capita income of the over 85 population was only $7574 in 1985.

These numbers have real, painful consequences: families are losing their life savings paying for long term care. I have received hundreds of letters in the past year asking for better protection against the costs of long term care. Let me quote from just one of these letters:

> [My wife] came down with a brain tumor. I took her to Rochester, Minn. to the doctors down there. They operated on her but she was paralyzed on the right side for the rest of her life. She died four years later. Those four years took everything I had. It left me in debt....I know how it hurts to get into that situation.

Many of these letters point out that neither Medicare nor private insurance pays for most long term care expenses. Instead, as noted above, many people are impoverishing themselves to qualify for Medicaid. In North Dakota, within 6 months 44% of all who enter a nursing home as private pay patients have exhausted their life savings and gone on Medicaid. And a House Aging Committee report found that over 60% of the single elderly would be impoverished by just 13 weeks in a nursing home. For elderly couples, the statistics are only slightly less grim: more than half would lose their savings in less than a year.

What we have, then, is a large and fast-growing demand for long term care, and only limited formal programs for providing that care. When infirm senior citizens must be cared for in the home or institutionalized, the financial and emotional burdens on their relatives can destroy their families. This is unacceptable. As long term care spending increases over the next several decades, we -- experts, providers, the Congress, and consumers -- will have to find a way of meeting these costs and of controlling them.

What are some of the options and what are their drawbacks? I want to briefly sketch some of the options currently under consideration in the Congress, and then I'll leave it to the witnesses to discuss them in greater detail.

In the 100th Congress, long term care proposals ranged from establishing a package of universal, comprehensive benefits provided entirely by the public sector to providing only very limited expansion of public benefits and instead encouraging the development of private sector solutions. At the former end of the spectrum were bills such as Senator Kennedy's Lifecare Long Term Care Protection Act. One part would cover the full cost of six months in a nursing home for anyone -- young or old -- who was unable to perform at least one activity of daily living. This would be fully financed by public funds. A second part, analogous to Part B of Medicare would be voluntary. It would cover longer nursing home stays and be financed partly by premiums and partly by federal funds. Other models along this line -- Rep. Waxman's Elder-Care Long-Term care Assistance Act and Rep. Stark's Chronic-Care Medicare Long-Term Care Coverage Act -- would establish a new Medicare Part C to provide comprehensive long term care benefits financed by a combination of premiums and federal funds, with varying deductibles and coinsurance.

Proponents of this approach argue that a universal program is needed to generate broad support. Everyone -- rich and poor alike -- faces the risk of needing long term care, so everyone should contribute and receive the benefits. Further, by providing the widest possible risk pool, the program will be most cost-effective. However, comprehensive universal programs like this cost a lot. Cost estimates range from $20 billion per year for the Lifecare program to $50 billion per year for Medicare expansion. And opponents argue that if these benefits are made too readily available many persons who are now giving informal care will choose instead to rely on the federal program, increasing utilization and total spending on long term care services.

A modification of the universal approach is to provide Medicare coverage for home care. This approach, spearheaded by Claude Pepper, would provide long term home care services to chronically ill elderly, the disabled, and children who have limitations in at least two activities of daily living. The majority of the elderly would prefer to receive long term care in their homes rather than in an institution, and this legislation would make it possible for those elderly who cannot currently afford home care to do so. And, proponents argue, home care is in general cheaper than nursing home care. However, opponents again point out that this approach could greatly expand utilization as formal home care is substituted for the informal care now being provided by relatives.

More generally, public sector approaches raise the problem of financing. Given the budget deficit, everyone agrees that we cannot simply create new programs without making provision for their funding. However, a recent poll found that 68% of respondents would be willing to pay increased taxes in order to have a program of long term care for everyone over the age of 65. Among the options being considered are: eliminating the $45,000 cap on earnings subject to the Medicare payroll tax, increasing the payroll tax, taxes on cigarettes or liquor, and an inheritance or gift tax.

Finally, at the other end of the spectrum are proposals to encourage private sector solutions. Some of these suggest incentives for couples to save for long term care, such as tax code modifications. Another possibility is the conversion of older homeowners' equity into a source of funds for long term care. But by far the most discussed private sector initiative is private long term care insurance. Proponents point out that we cannot rely exclusively on public sector solutions because the current growth in health care spending is already alarming. Given the current budget deficit, they argue, it would be irresponsible to create new entitlement programs which may result in large and unpredictable expenditures. And demographic trends will make it difficult for a relatively small working age population to support programs utilized by a growing elderly population. Further, they argue that economic trends suggest that in the future the elderly may be better able to afford the expenses of long term care.

Private long term care insurance is a new industry, which, while it has grown very quickly, still accounts for only a tiny fraction of long term care spending. However, because insurance is currently available for a wide range of health care services, "Medigap" insurance is popular among the elderly, and data on nursing home utilization make it an insurable event, proponents believe there is potentially a large market for private long-term care insurance. They find private insurance attractive because those who use long-term care would pay for it and could choose the coverage best suited to their individual needs.

However, there are several drawbacks to private insurance. Because those seeking insurance are those most likely to need long-term care, insurance companies have protected themselves by charging very high premiums, offering limited benefits that in most cases are not indexed to inflation, and excluding care related to pre-existing conditions from coverage. One recent study of long term care insurance found that the average probability of not collecting any benefits from private insurance is 61%; only 18% of all plans offer consumers even a 50% chance of receiving any benefits. And those most likely to need long term care are least able to afford the high premiums -- especially given the limited benefits.

Legislation such as that proposed by Senator Mitchell to provide incentives for individuals to purchase private insurance would solve some of these problems. By capping the risk for insurance companies, greater benefits could be offered for lower premiums. However, the insurance companies are skeptical; they point out that the vast majority of nursing home stays are shorter than the proposed caps. Consequently, their risk would not be substantially lessened. While proponents hope that expanding long-term care insurance to a larger pool -- either through tax-incentives or through employer-based group coverage -- will diminish the adverse selection faced by companies and result in lower premiums, a Brookings Institution study suggests that, even under the most optimistic assumptions, private insurance will pay for only a small fraction of long-term care costs in the future.

In conclusion, there is clearly a growing need for long term care, and the present method of financing is unacceptable. We cannot allow our senior citizens to impoverish themselves and their families as they attempt to meet the crushing costs of long term care. Yet government expenditures on health care in general and long term care in particular are soaring, so sole government financing of long term care seems infeasible. While no consensus has yet emerged, we must find a combination of public and private initiatives to meet this problem. I hope this hearing will dramatize the urgency of the problem and stimulate the debate on the solutions, particularly as they relate to the problems of providing care in a rural setting.

Now I'll leave it to the experts to discuss the issue and possible solutions in greater detail. But first I'd like to hear from some people who can translate the numbers into reality, people who have had to meet the crushing costs of long term care.

Senator CONRAD. To begin our discussion I'm very pleased to introduce Dr. Kevin Fickenscher who is the director of the Center for Rural Health in Grand Forks, someone who is a respected expert not only in our State, but somebody who is respected nationally for his knowledge of the special problems of rural health; Dr. Fickenscher.

Let me just indicate while Kevin is coming to the desk the rules that we operate under when we are conducting a hearing that is an official hearing of the Senate Budget Committee. We ask witnesses to give us an overview of their testimony. Their entire statement will be entered into the record. We don't allow any interruptions of a witness, that is, we ask anybody if you disagree strongly with a witness, please don't interject and make a comment while a witness is testifying. We will give people an opportunity as we go through the day to express themselves and have a chance to register their opinions and ask their questions.

So with that in mind, welcome, Dr. Fickenscher. I very much appreciate your participation and also your help in setting up this set of hearings. We also appreciate that.

STATEMENT OF DR. KEVIN FICKENSCHER, DIRECTOR, CENTER FOR RURAL HEALTH, GRAND FORKS, ND

Dr. FICKENSCHER. Thank you very much. It's my pleasure to be here. I also want to thank you for encouraging the audience not to throw eggs and tomatoes and stuff like that. I appreciate that. It's a real distinct pleasure to be here and I'm really pleased that you're talking the initiative to highlight some of the very important issues that are facing us in health care, in particularly related to long-term care as we're going to be discussing today.

As you know and as you're already pointed out I serve as the director of the center for Rural Health at the University of North Dakota. I'm going to be talking to you today from a rural perspective trying to highlight some of the issues because I think that we need to consider that given the fact that North Dakota is a very rural State and many of the issues that the elderly face in this State particularly relate to some of the issues surrounding that. I should also like to point out and thank you for your leadership of the Senate Rural Health Caucus. The Rural Health Caucus has done an outstanding job of highlighting the issues of rural health and I know that you've been one of the leaders in that group and on behalf of North Dakota I want to thank you for those efforts.

If we look at the issues surrounding elderly and look at the percent of elderly that have, as a percent of population back in 1880 the elderly represented a mere 3 percent of the total population and today it's around 11.3, 11.5 percent of the total population. Barring any changes in our immigration policy or any sudden changes in the number of children that are born to particular families we can anticipate that by the year 2020 that fully, 17.3 percent of the Nation's population will be over the age 65. That is a very dramatic population shift that's going to have some profound implications not only on health care services but the whole demographic structure of our Nation.

In particular as we look at the rural areas and the smaller towns we are already facing a situation where the rural areas are experiencing what we're going to be facing in the year 2020. If we look at communities of 10 to 50,000, we already at 12.9 percent of the population over the age 65. 2,500 to 10,000 it's about 15 percent, and if we get down to less than 2,500 it's very common for those communities to be over 16, 16½ percent. So in essence what we have is a situation wherein rural America today we have a microcosm of what the Nation will be facing in the year 2020.

I think one of the things we need to recognize is that also, even though that represents problems it also represents an opportunity and that perhaps we should invest in that opportunity as we try to develop methods for coping with the needs of long-term care. You so amply pointed out some of the issues related to long-term care as it relates to nursing homes. I'd like to point out that that represents a small percent of the entire long-term care problem as you know and we also need to be looking at the more, the other spectrum of services that are very important for the elderly.

And then finally the reimbursement issue. One of the problems that has been highlighted in the Senate and on the House and is something that is being debated on a regular basis is the whole reimbursement structure and how it tends to favor the large urban center and it doesn't favor the rural settings and I think we need to address that problem and I know that you've been involved in those discussions and I believe that's been very helpful.

There are four considerations that I'd like to highlight as we talk about long-term care. One of them is availability, access, payment strategies, and then finally comprehensiveness. I'm going to do those very quickly. I provided you with some written comments to expand upon it.

On the issue of availability I think that we need to recognize that our current long-term care system is very fragmented. We have multiple sources of funding and that creates a situation of consternation for the elderly. If you're trying to gain access to health care, to try and do that now in the current long-term care environment is a very difficult situation. The availability is often a real problem in our rural areas. For example, my Grandpa John just recently had surgery and he lives in a small town south of Minot, Makoti, North Dakota and the problem in Makoti is that home care services, home chore services really aren't available, and so he was almost forced into a situation where he had to move to a larger urban center for a period of time for his recovery simply because services were not available. The reason they were not available in part related to the fact that the reimbursement system does not allow for taking care of a sparse populaton basis, et cetera. So those are some of the issues that relate to availability.

In terms of accessibility there is a lack of information on services, there's often very confusing rules and eligibility criteria, and I also think that another issue related to long-term care and access is that access should not be limited to a small array of services. Under medicaid a lot of emphasis on institutional care. Clearly we need to move beyond that. We need to provide a whole spectrum of community based services because community based services I think are really the answer. Most of the elderly as they reach a pont where they need help don't want to move into an institution. They want to stay in their own homes.

On the area of payment, once again fragmentation. We've got medicare that's funding acute and rehab services. We have medicaid that funds institutional long-term care. We've got the Human Services block grants, the older American Acts which funds nutrition, wellness programs, et cetera, so that in some ways we have a plethora of funding and a posse of understanding about how to gain access to that whole system and I think that's a real problem.

Finally, comprehensiveness. I think that for a long-term care system we need to have the availability to pick and choose those pieces that are important for the individual elder. The ability to put together an individualized package, if you will, for that person who has a particular health care problem.

On all of these issues I think that the one thing we can recognize is that long-term care services should be part of an integrated package of services. We've set up in this Nation a system of fragmented service that are sort of all over the map that really aren't integrated very well and if there's anything that can be done from a policy perspective to try to allow for integration, that we should try to do that.

The second thing that I think is a lesson that we've learned over the last decade is that wherever we put our health care dollars is the kind of health care system we're going to get and that's really come home to me with the implementation of the DRG's and the prospective payment system and all of that. If we want primary care, then we have to invest dollars in primary care. If on the other hand we say, well, we'll pay for technology, we're going to get lots of technology. The same goes for long-term care, if you want an integrated health care system, then let's put dollars forward that support an integrated health care system.

Also I've talked about the rural issues and the fact that for our rural hospitals and our rural nursing homes reimbursement is a major issue and I know that you're aware of that and working on that issue. Another issue I think is equally important is that many of our rural hospitals as you know were built in the late '40s and early '50s and were built with Phil Burton dollars and we're trying to have those institutions take on a role of providing long-term care services with an acute care facility. When General Motors decides it's not going to build Cadillacs, its going to build small cars, it retrofits its plans. We need the same sort of strategy for our rural hospitals. We need to help them because if they're going to deliver care in an effective way, they need some help in that area.

And then finally to come back to the issue of rural America being a microcosm of where the Nation is at. I think that's an opportunity. One of the things I would encourage you to consider and think about a little bit is taking some dollars and investing in some research and program development in some of our rural communities to study how we might deliver care for a population that is 20 percent over the age of 65. You go to any small town in rural North Dakota and that's a real issue. That's a reality, so let's maybe look at that. See what we can do for delivering care in some of these small towns and use those examples for the Nation as a whole as we approach the next century.

I know we're limited on time and so I tried to cut down my written comments and I'd be more than willing to answer any questions you might have.

Senator CONRAD. Thank you, Dr. Fickenscher. We very much appreciate your testimony, especially appreciate the written testimony that you've provided, it's excellent, and is going to help the Senate Budget Committee as we tread through this thicket.

[The prepared statement of Dr. Fickenscher follows:]

Senator Conrad:

Thank you for inviting me to share my perspectives on the important issues facing our nation related to long term care services for the elderly. My name is Kevin Fickenscher. I am a Board-certified Family Physician and Associate Professor of Community Medicine and Rural Health at the University of North Dakota School of Medicine. Since 1980, I have served as the Director of The Center for Rural Health at the University of North Dakota, a nationally recognized program involved in assisting rural communities sustain quality, local health services; and conducting research and policy analysis. As you already know, my perspective is heavily influenced by the rural needs of the state and the nation.

Before proceeding, I would like to express my very sincere appreciation to you for all of your efforts on behalf of North Dakota in the United States Senate. In particular, your role as a member of the Senate Rural Health Caucus in highlighting the concerns of rural America and it's health care system have been crucial. You have consistently taken a leadership role with the Caucus in advocating needed changes in our nation's health policy which reflect the interests of rural America. As a rural health advocate, I am extremely pleased to have your assistance in the United States Senate.

During the brief time I have allotted to me, there are a number of specific issues I would like to highlight for your consideration. Before proceeding, however, I would like to provide a short overview of the environment for long term care services in rural America.

- in 1880, the 65 and over age group totalled less than 2 million people and represented only 3% of the nation's population. In 1980, we were a nation with 25.5 million elderly or 11.3% of the population. Barring a change in immigration policies or a sudden, dramatic change in the number of children born to each family, it is anticipated that by the Year 2020 the elderly will represent 17.3% of the total population in the United States. Clearly, such a demographic shift will have profound implications on how we as a nation allocate our resources both within the health care field and more generally.

- data from the U.S. Census Bureau reveals that as a town becomes smaller in population, the percent of the community over age 65 increases. For communities of 10,000 - 50,000 people, the elderly represent 12.9%; for 2,500 - 10,000, 14.7%; and, for less than 2,500, 15.4%. In essence, we have in the rural communities throughout the nation a microcosm of what the nation will be facing in the year 2020. We should look at that as an opportunity to develop new and effective strategies for delivering the spectrum of health services for the elderly.

- the average life expectancy in 1880 was 45 years. Today, it is 69.9 years for men and 77.6 for women. Nearly 80% of the population today can expect to live past their 70th birthday.

- only 5% of the older population resides in some type of institution. It is clearly evident that the major needs then are with community-based services.
- the most common health problems of the elderly are: arthritis, hypertension, hearing and visual impairment, heart conditions, orthopedic impairments, sinusitis, arteriosclerosis, diabetes, and varicose veins.
- the elderly account for 25% of all prescriptions, 33% of all hospital admissions and 30% of the revenue for hospital beds. In the area of long term care, the elderly represent the bulk of services provided in most communities, especially in the rural areas. As a result, rural hospitals and nursing homes are quite dependent upon policies established for Medicare and Medicaid. Despite increased sensitivity to rural needs, these programs continue to reflect a strong urban bias from a reimbursement perspective.

These issues and trends represent a background upon which we can consider the critical questions facing our nation in the area of long term care delivery. It seems evident that the major questions related to policy in rural long term care revolve around four major considerations: availability, accessibility, payment strategies and comprehensiveness.

1) Availability. For most of our rural communities, services are often unavailable due to the fragmented nature of the health delivery system. There are different points of access, different funding sources which too often preclude cooperation between programs, different eligibility criteria and different methods of payment for services. Not only is it difficult for the health providers to determine which services are available, but you can imagine the consternation of the elderly as they try to gain access to the system. A good example is that of my Grandpa John Bigelow. Grandpa John recently had surgery in Grand Forks for a relatively simple procedure. He decided to against having the procedure done in Minot although it is significantly closer than Grand Forks to his home. The major deciding factor in determining the location of the surgery related to availability of home services. In his home community of Makoti, no home care services were available. In Grand Forks they were available if needed.

2) Accessibility. Long term care services are too often inaccessible in rural areas. The lack of information on services and the confusing rules and eligibility criteria create difficulties for those attempting to gain access to the system. We also need to recognize that access should not be limited to a few select services. The nursing home is but one choice available for the elderly in need of long term care services. A case management approach which assists the elderly to develop an individualized package of services selected from the spectrum of long term care services is a better approach. Case management is an effective, cost-efficient approach for increasing accessibility to services for the elderly.

3) Payment Strategies. Our current system which keeps separate the acute care system from the long term care system results in further fragmentation of services for the elderly. Medicare covers acute and rehabilitative care; Medicaid provides public, institutionalized long term care with a waiver for home and community-based services; the Human Services Block Grants support most of the programs of our county social services; the Older Americans Act focuses on nutrition, health and wellness and other community-based services; private insurance covers some selected services; and, the Department of Transportation supports senior transportation programs. We face a plethora of funding sources and a paucity of understanding on how best to gain access to the system. It seems self-evident that the fragmentation of the payment system results in a fragmented approach to providing long term care.

4) Comprehensiveness. In the past our long term care system was geared toward an institutionalized approach. We now recognize that the best approach is to pick and choose from a spectrum of services to create an individualized package of services for the elderly. The continuum of services needed for a comprehensive approach to long term care ranges from homemaker services, to home health aides, to respite care, to chore services, to family home care, to congregate meals programs, to meal-on-wheels, to adult day care, to foster care, to hospice care, to nursing home care and all the other permeations and possibilities in between. The reimbursement system does not reflect this need.

Based on the above discussion, there are several recommendations I would like to make as you reflect on the best approach we as a nation care take for delivering quality long term care services in the future.

First, we must recognize that to the extent feasible **long term care services should be available as part of an integrated package of services provided to the elderly**. The need for flexibility in designing individualized packages of services for the elderly represents an important step forward in responding to the needs of the elderly.

Second, **the health care system will go in the directions where we place the health care dollars**. If we as a nation place a high priority on primary care, services will be provided in primary care. If we place more money in reimbursing technology, we will get technology. If we want an integrated long term care system but fund programs individually, we can expect to have a fragmented approach to health care delivery. We must never forget that the most important decisions relate to how we will allocate the dollars which drives the system.

Third, **any health policy in long term care must recognize the unique issues involved in delivering care in rural areas**. If we develop a home health reimbursement system that does not allow for travel time as a component of cost, can we expect that there will be home health agencies attempting to deliver care in sparsely populated, rural areas. Probably not! If we reimburse rural physicians less than urban physicians despite the fact that no differences in the costs of their practices can be demonstrated, we can expect that it will be difficult to attract and retain physicians in rural areas. If we apply requirements and standards that do not allow for integration of services, it will be difficult if not impossible for many rural areas to provide the full spectrum of long term care.

Fourth, **the nation's rural hospitals are ill-equipped to be involved in the provision of long-term care services from a structural perspective**. The bulk of our nation's rural hospitals were built with Hill-Burton dollars during the last 1940's and early 1950's. Those facilities were built to provide limited acute care. If we are expecting our rural hospitals to become more involved in the delivery of long term care -- as I believe we should -- we will need resources to retrofit these facilities. General Motors when it decided to make smaller cars didn't simply empty out the Cadillac factory are start building small cars. It invested in retrofitting the factory to build the right type of car. We need a similar strategy for our nation's rural health system.

Fifth, **coordination of the many different services available for the elderly is imperative**. I believe that we need a "Comprehensive Health and Community-Based Services for Older Americans Act" to allow for re-integration of the many programs currently available to the elderly.

Finally, **rural America is a microcosm of the nation in the Year 2020. We should invest now in research and program design in our rural areas as an investment in the future of our health care system**. Rural communities could very easily be the sites of demonstration projects for evaluating new approaches toward case management and service integration. The resources are easily defined in a rural setting, the numbers are not so large and the providers readily available for attempting innovative approaches. The lessons from a series of rural health long term care demonstration projects could provide very useful information for all of us who are concerned about the structure of our future long term care system.

Thank you for the opportunity to present my perspective on the major issues facing our long term care system. I would be more than willing to answer any questions.

Senator **Conrad**. Obviously if we're looking at this from the perspective of the Budget Committee, we are faced with an extremely difficult set of facts in Washington. And just briefly to set the stage and put this in context, we have a deficit that's running $50 to $60 billion a year. We're, frankly, making very little progress at reducing that deficit. Everybody remembers 2 years ago when the joint leadership of the country, the president, the Republican leadership and the Democratic leadership had a summit on the budget deficit and remembers what they said they were going to do? They were going to reduce the budget deficit $70 billion over the next 2 years. Anybody remember what the budget deficit was 2 years ago? $155 billion. Now after the 2 years of this plan in which we were supposed to reduce the deficit $70 billion, anybody know what the deficit is going to be this year? $170 billion. So instead of going down $70 billion, it's actually gone up $15 billion.

And the true story is even more difficult because the true story is the actual deficit is significantly larger because the social security surplus is growing and the social security surplus counts against the deficit that we announce as the bottom line deficit of the country. Instead of saving the social security trust fund for the day when the baby boomers will become recipients of social security funding, we're borrowing the money to make the annual operating deficit look smaller.

And so you can see the Federal government is in a very precarious position. Large additional funding for any number of programs that are worthy is going to be a very difficult thing to do. And on the other hand there are these unmet needs, the needs that Dr. Fickenscher has described. And, frankly, there are probably no needs that cry out more clearly for addressing than the needs of our elderly and the needs for long-term care.

Dr. Fickenscher, let me ask you this question, if you were able to fashion a policy, the Federal government said to you, Kevin, you are the one who is going to decide this and you have 5 minutes to outline, what would be the principles upon which you'd structure a plan to deal with the problem of long-term care? What would be the first things based on your experience that you would want to see happen?

Dr. **Fickenscher**. Well, one of the very first things I think is that one of the overriding principles I guess that I would encourage is that we need to invest now for the future. What I'm suggesting is that we're the baby boomers. We're the ones that are going to stress the system. We're the ones that are going to potentially collapse the system, and if we don't take the responsibility now to invest for our future long-term care needs, much like we invest in social security, then I think that the Nation as a whole will be very hard put to provide the kinds of services that clearly our generation is going to expect.

We are a very loud and vociferous generation. We have been ever since the 1960s, at least for myself. I can't speak for you, Senator Conrad. I used to walk around with long hair and wear jeans and all that kind of stuff. I've changed. I don't think you were ever that way. But I think that that is an issue. We need to invest now for the future.

That's one principle and as I look at some of the polls I know that, for example, the Association of Retired People have done some polls and families, people of our generation are willing to make those kinds of investments if the dollars are going to be put into some sort of a trust and used for those purposes. I know that in my own case I'm very willing to do that and I know that probably most people would be if they knew those dollars were going to be there rather than retiring the deficit or whatever purposes need to happen as well, which are all equally important issues.

Second thing is I think there does need to be a portion of care that probably does come out-of-pocket. When people pay a portion out-of-pocket, they recognize what they're buying and I think that that is something that we've learned in health care. I think that we also at the same time need to recognize that certain individuals have more resources than others and that we need to take into account those limitations.

And finally there does need to be some sort of catastrophic approach. There are certain kinds of long-term care expenses that are clearly catastrophic and that can be done in an insurance mechanism and there are also—that kind of a program would have to be supported through tax dollars, et cetera, and there's lots of proposals that are being floated about using cigarette tax, syntaxes, et cetera, to pay for those kind of services.

Senator CONRAD. How much focus would you put on the, what you described as community base services and what do you mean by community base services? What does that mean to you?

Dr. FICKENSCHER. Well, community—first of all, I would put a lot of focus on community base services because I think that that's generally the types of things that are most needed by many of the elderly. What I mean are chore services, homemaker services, nutrition services, meals on wheels, congregate housing. A lot of the kinds of things that are generally available but they're not available in sort of a fragmented patchwork. They're not tied together and I think that's the basic problem with our long-term care system is that we have a lot of patchwork. We have a lot of individualized services that are out there but they're not tied together in any cohesive fashion and it's very hard to try to figure out how to gain access to any one piece of it. So those are the types of community services that I think need to be emphasized.

Senator CONRAD. Let me do this now, we have somebody who is really unusually expert in this area and I'd like to open it up for the audience. If you don't mind, if you've got some time to stay, I'd like very much to give this audience a chance if they have questions to have a chance to get an answer from Dr. Fickenscher. Anybody that's got a questions? Any other questions? All right. If nobody has——

Dr. SKOKEVO. Yes; I do because I've spent most of my life taking care of sick people and——

Senator CONRAD. If you'd just identify yourself.

Dr. SKOKEVO. I'm Dr. Skokevo I was in Karlstad for 20 years taking care of sick people in an extremely remote area and I don't know the answers becuase the problems are very complicated, but the most important thing is that we keep some freedom in this. An if we get Federal care to take care of the counties, we're going to lose a lot of that freedom and it's going to cost a lot more. And you came close to the answer, Dr. Fickenscher, when you said that community base services, we have to have the control in the local area. Now if the money doesn't come from the local area, the control will not be there and you know that.

This is our big problem with medicare today. The control is not in the local area and so we have rules. I was on the board of a rest home. We had 29 inspections in 29 days. We changed one door 15 times. That one door cost us $18,000 and I still don't know what happened to that door, but the reason was we had Feds coming in, we had State coming in, we had county and every bureaucracy you can think of coming in there to tell us how to run that rest home. It was one of the best rest homes in the country, it still is. But the cost was astronomical because of all the inspections.

We need to keep all of the control as local as possible. I know it can't be entirely, but that's the secret because if we don't, we're not going to get the care. It's going to be fragmented more. The more you come from Washington the more fragmented it's going to be. The more local it will be, the more in point it will be to people, the ones who need it, so county welfare agencies can do a very good job.

Senator CONRAD. Dr. Skokevo has a very good point that I would like to reiterate, the need to have local community base, by community base being local flexibility. I think one of the problems that we have in our current health care system is that there isn't a degree of flexibility that can take place at the local community level and that's been one of the problems, particularly in our rural areas as they try to deliver services and I think he raises a very good point about the need to understand local situations.

Yes, sir?

Mr. LINDSAY. The doctor gave his opinion. I'm going to give you mine.

Senator CONRAD. If you'd come to the mike and identify yourself.

Mr. LINDSAY. My name is Arnold Lindsay. Now we got about 20,000 households here in the city of Grand Forks and probably 97 million in the United States. You multiply them by $200 a month for what we're paying into insurance company to administrate their business, their offices, 20 percent to their agents, and if we put that into a Federal universal program, we'd have something second to none plus the medicaid and a little bit more of what we're paying.

As far as the doctor saying no local control, that's the trouble. We don't have no control. And now as far as finding out about this medicare, the only industrial country in the world except us and one in Africa got universal medicare and it's working out. The people are taken care of. No; why don't the people want it here? The special interest groups don't want no control. People all know this, but they're afraid to express themselves. Now you can go up to Canada.

If the people in Washington can't put a medical bill together, they can but they don't have the will to do it. We know that. You're smart enough, Kent. You can. I know your background. If you go back to Washington and tell them fellows who make all these trips to foreign countries and Canada, check on their Medicare Program and you'll come back with a program and we'll have the best in the world. It's just that simple. The money that's threw away on big Cadillacs, and all this money thrown around, we can have anything. All we got to do is put it together. It's that simple.

[Applause.]

Senator CONRAD. Thank you very much. Let the record show that there was applause for that position. Other questions or comments?

Well, let's go to our next witness and, Kevin, again a special thanks for helping us put these hearings together in North Dakota.

Next we are going to hear from Ron Bunnell, the president of Lutheran Home Health Care Services of Fargo. Welcome, Ron. Very much appreciate your taking the time to be with us here today. Again if you'll summarize your testimony, we'll enter the full written statement into the record and then have time for questions.

STATEMENT OF RON BUNNELL, PRESIDENT, LUTHERAN HOME HEALTH SERVICES, FARGO, ND

Mr. BUNNELL. Thank you for the opportunity to speak here. My name if Ron Bunnell. I'm the president of the Concord Home Care. We're a subsidiary of Lutheran Health Systems which is a nonprofit organization based in Fargo. We have a 51 year history of providing rural health care. We have 37 hospitals, 27 nursing homes, one school for disabled children, and 34 freestanding home health agencies. I'm in charge of home care. Concord provides nursing and home health aid services in the home and also sells and rents home medical equipment.

Home care covers many situations. We had a patient whose foot was infected after a fishing trip. We provided antibiotics in the home which was easier and more cost effective than in a hospital or physician's office. For another patient we provide personal care services. This involves, this can involve giving a bath or preparing food. We have another patient who we provide wake-up services to in the morning help him with the personal needs, and preparing his breakfast perhaps getting him on a bus to a senior center. Home care can involve changing a dressing, teaching about medications or breathing techniques or how to walk or talk again.

Our goal in home care is to enable people who are frail or dependent to stay in their homes as long as they can with the lowest level of intervention. The visits can range from 15 minutes to 24 hours, 1 to 7 days a week. The best candidate for long-term care is someone who is semidependent, able to stay by him or herself and able to move around the home. For example, we have a patient, Jane, who is 82 years old. She has diabetes. She has poor vision and difficulty with bathing. A nurse comes to her home once a week to set up her medications and perform an assessment. An aide comes twice a week for about 3 hours. When the aide arrives, she will put laundry into the washing machine, she will help Jane with her bath, do light housekeeping and get groceries. We provide all these services for about $50 a week.

There are many, many situations where it is more cost effective and we can provide the appropriate level of care in the home. In a long-term care program it's important to have flexibility and choices. This will necessitate the need for a gate keeper or a case manager who can determine the appropriate level of services and where the services should be performed, whether it be in a home or in an institution. In a long-term care program the benefits for home care must move beyond the current medicare model. We must provide preventive care, chore services, social support, and anything else that enables older people to remain independent in their homes.

It's critical that there not be an urban-rural distinction in the reimbursement levels. Labor costs are typically lower in rural areas, but transportation costs are higher. We can rely on competitive forces and case management to keep costs down. Home care does not have to be expensive. We charge about $7 an hour for aide services. The majority goes to the employee. Effective long-term care in the home allows people to remain happy and independent. Home care has to be part of an integrated long-term care system. Their own home is where most people want to stay as long as they can.

Senator CONRAD. Ron, let me pursue something that you just mentioned. It's a follow on to what Dr. Fickenscher indicated. He talks about community base services. You've talked about home care as being a major component of anything we do. Understanding that we're going from 2.8 million or roughly that number who are in position and need long-term care today and we're expecting when the baby boomers hit that we'll have 15 to 18 million who are going to be needing long-term care. It's that kind of explosion of the population we're looking at. Obviously they're not all going to be taken care of in institutions. There's no way to do that and so home based care becomes a very major component of anything we do.

Have you analyzed or has your organization analyzed the difference in cost between keeping somebody at home with help from outside and having somebody in an institution?

Mr. BUNNELL. It's important to have a situation where a case manager can assess each individual case and determine where it is more cost effective to receive the care. We have patients that were in nursing homes paying about $65 a day who we've been able to move into the home with a minimum level of services and in some cases be able to reduce that cost to $100 a week range. Significantly reduce cost. There have been studies done around the country which have shown that home base programs can be done for about 60 to 70 percent of the cost of home care for individuals that fit in the appropriate situation.

Senator CONRAD. And what are the, what are the bundle of home health care services that are provided? You've mentioned several today in terms of helping with laundry, help bathing, help with a series of things. What are the bundle of services? In other words, to what level of intensity of care can you go in a home based program?

Mr. BUNNELL. We provide a full range of services in the home including high tech home care for people that have been immediately discharged from the hospital, and the amount of services that you can provide in the home is increasing not only because of changes in technology but also because of a greater acceptance in the medical community for home care services.

When we're talking about long-term care, we can deal with chore services, bathing, people that need help with normal activities of daily living such as bathing, dressing, eating, toileting transferring. The services that we provide I think need to be flexible because people have different needs and if there's any component to a program, the most important thing is that it offer flexibility. What we want to do is provide the care for the person with the lowest level of intervention.

Senator **Conrad**. What number of clients are you dealing with in a home health care situation?

Mr. **Bunnell**. We make approximately 250,000 visits a year in the home.

Senator **Conrad**. 250,000. And what is the primary source of financing? In other words, what are the reimbursement modalities that you have?

Mr. **Bunnell**. Currently there is, ther is no reimbursement provided Federally for long-term care in the home. Our principal care in the home is intermittent care which is for people that have been discharged from the hospital and medicare will pay for intermittent care. For our particular company about 50 percent of our revenues come from medicare and medicaid.

Senator **Conrad**. And the other 50 percent?

Mr. **Bunnell**. The other 50 percent is private pay or insurance.

Senator **Conrad**. And have you got some division between insurance and actual out-of-pocket for people?

Mr. **Bunnell**. That again is split about 50–50.

Senator **Conrad**. So about 25 percent of the total would be out-of-pocket by individuals, 25 percent private insurers and the rest medicare, medicaid?

Mr. **Bunnell**. That's correct.

Senator **Conrad**. Questions from the audience? Yes, sir.

Mr. **Bakken**. You didn't mention, don't they take those who are destitute and on welfare?

Senator **Conrad**. Judge Bakken, if you'd just identify yourself for the record.

Mr. **Bakken**. A. C. Bakken, and I was wondering with the volume you apparently handle do you exclude those who are on welfare?

Mr. **Bunnell**. Absolutely not.

Mr. **Bakken**. Where do those payments come from?

Mr. **Bunnell**. We do provide some charity cases. We also work with local social service agencies and medicaid will pay for some programs. We are in a variety of States and the State regulations do very, but there are States with community base programs that pay for people that are unable to make the payments themselves.

Mr. **Bakken**. What percentage is that?

Mr. **Bunnell**. The percentage that medicaid pays for is included in the 50 percent of medicare and medicaid. I lumped that in there with the State programs.

Senator **Conrad**. Ron, if I might ask, what do you see as the demand, if there were, if funding were not at issue, what do you see as the potential demand out there based on what your company's experiencing around the country?

Mr. BUNNELL. I think most people want to stay in their home as long as they can. If funding were not a limitation, the demand for home care would go up and the demand for going into nursing homes would certainly go down.

Senator CONRAD. Do you sense that right now there are people in nursing homes who could be taken care of at home and that there would be substantial cost savings?

Mr. BUNNELL. There are people in nursing homes that could be taken care of in their home and there have been several studies. I'm familiar with one where about 26 percent of the people that were being discharged from hospitals that normally would have gone into nursing homes went into home care and those people received services in their home for 60 to 70 percent of the cost that it would have cost to be in a nursing home.

Senator CONRAD. All right. Other questions?

Mr. EBERLY. I'm Vern Eberly, and I'd like to know how widespread your services are. I live in Grand Forks. You're based in Fargo. Are you—would I be able to get services from your organization?

Mr. BUNNELL. In Grand Forks we have limited services. My organization only provides home medical equipment in this community. There are, however, hospital based home health agencies as well as freestanding home health agencies in Grand Forks.

Ms. SNYDER. My name is Mary Snyder. I'd like to respond to his question. I used to be a home care nurse in Grand Forks through United. We have a United home care network that provides skilled nursing services, high tech home care equipment services, supply services, hospice service, and private duty nursing.

Senator CONRAD. Would you explain just for the benefit of the group, I think it would be very helpful, what is a hospice service versus a high tech service? What are the differences between those?

Ms. SNYDER. Many of the services we provide, we might have all of our programs in one home at the same time. We've had that happen. The hospice program provides care for the terminally ill and I do not work directly with that program, but we interface very closely. But there are more and more people deciding that that's where they choose to die is in their home, so when that is the decision, often times these people will need skilled nursing services along with it, then we can provide personal care services in the home. We can actually make almost a hospital in the home. We can get the hospital bed in there, oxygen equipment in there. We can get just about anything. We have provided home care ventilator services in places as far away as Walhalla where we have served them here out of Grand Forks.

So we have a lot of services available and unfortunately as Dr. Fickenscher has said and this gentleman here, I think that it's so fragmented that people don't know how to get into the system and tap the services that are available.

Senator Conrad. Thank you very much. Ron, I want to thank you very much for being with us today for your participation, your excellent written testimony.

[The prepared statement of Mr. Bunnell follows:]

TESTIMONY BY RON BUNNELL
AT THE SENATE BUDGET CONFIRMATION HEARINGS
GRAND FORKS, NORTH DAKOTA

FEBRUARY 14, 1989

LONG-TERM CARE PROVIDED IN THE HOME

I. Background on Lutheran Health Systems and Concord Home Care

A. Lutheran Health Systems is a nonprofit health care services corporation based in Fargo, North Dakota.

B. The company has a 51-year history of providing rural health care through its subsidiary, Lutheran Hospitals and Homes Society.

C. In the LHS multisystem, there are 37 hospitals, 27 nursing homes, one school for disabled children, and 34 freestanding home health agencies. The facilities and agencies are in 14 states, primarily the midwest, southwest and Alaska.

D. Annual revenues for Lutheran Health Systems in 1987 were $311,000,000.

E. Ron Bunnell is the president of Concord Home Care, a taxable subsidiary of Lutheran Health Systems. Concord provides nursing and aide services in the home and also sells and rents home medical equipment and supplies. Revenues for Concord in 1988 were $15 million.

II. What Is Home Care?

A. Home care covers many situations. It can mean giving antibiotics to Jack, whose foot became infected after a fishing trip. It's giving a bath to Molly, who at 86 can no longer bathe herself. It's helping Sam out of bed in the morning and making his breakfast. It's making sure Edward gets on the bus to the Senior Center every Monday, Wednesday and Friday. It's changing a dressing, teaching about medications or breathing techniques, or how to walk or talk again.

B. Home health is a service whose goal is to enable people who are frail or dependent to stay in their homes as long as they can.

C. The visits can range from 15 minutes to 24 hours, one to seven days a week.

D. The best candidate for home care is someone who is semi-dependent, able to stay by him/herself, and able to move around the home.

E. For example: Jane is 82 years old, has diabetes, poor vision and difficulty with bathing.
   1. A nurse would come once per week to set up medications and perform an assessment.
   2. An aide would come twice per week for a total of three hours. The aide would:
      a. help Jane with her bath
      b. do light housekeeping
      c. do laundry
      d. get groceries
   3. Total cost: $48 per week.

F. Other clients may not need frequent nursing visits but instead require an aide to visit one hour per day to help with meals. These services could be provided for approximately $60 per week.

III. Key Elements Of A Long-term Care Home Based Program

A. Programs currently in existence have shown that home care can be cost effective.

B. Case management is key to resolving the occasional conflict between quality of life and cost. Case management will also ensure the most efficient utilization of community-based services and keep induced demand to a minimum.

C. Eligibility for the program should be inability by the beneficiary to perform two or more activities of daily living (ADLs). These activities include: bathing, dressing, eating, toileting and transferring. A person should also be eligible if there is a need by the beneficiary for skilled nursing services (e.g. help with medication).

D. A large ($500) deductible for home care benefits and a 20% beneficiary co-payment would discourage induced demand. This deductible could be reduced if the beneficiary received significant help in the performance of at least two of the ADLs from an individual not receiving monetary compensation.

  1. This would encourage the involvement of family and friends which would reduce cost.

E. The benefits for home care must move beyond the current Medicare model to provide preventive care, chore services, social support and anything else that enables older people to remain independent in their own homes.

F. Any long-term care program must include both home care and nursing home coverage.

G. There should **not** be an urban/rural distinction in the reimbursement levels.

  1. Labor costs are typically lower in rural areas, but transportation costs are higher.
  2. Competitive forces and the case manager will keep costs down.
  3. The cost associated with migration of older people out of rural areas will be reduced.
  4. It is more costly to make frequent, short visits in a rural area.

IV. The Induced Demand Caused By The Creation Of A New Program Can Be Reduced By:

A. Having high deductibles.

B. Requiring co-payments.

C. Using case management.

D. Rewarding family members who provide services.

V. Long-term Care In A Rural Environment

- A. The case manager must have flexibility.
  - 1. The case manager has fewer service agencies to work with, e.g. meals on wheels may not service the area.
  - 2. Available services will vary greatly from one rural community to another.
- B. There will be a lower percentage of people in rural areas who would be able to receive long-term care in the home.
  - 1. In an urban area it is easier to have several short (15 minute) visits within one day. An aide can have a circuit of homes to visit.
  - 2. Emergency response time is slower in rural areas.
- C. There should not be an urban/rural distinction in the cost caps.
  - 1. Rely on the case manager to determine the most cost-effective program.
  - 2. A variation in cost caps would encourage migration out of rural areas to urban areas.
    - a. The migration costs money.
    - b. Can be disruptive to family life, especially if the move is motivated by the reimbursement methodology of a government program.

VI. Joan Quinn: Connecticut Community Care Model

- A. Designed a program to address the problems of:
  - 1. Segmented service.
  - 2. Cost containment.
  - 3. Bringing the right services to the client.
    - a. Monitoring and periodic reassessment.
    - b. Consideration to environment, health, family, financial resources.
- B. Hospitalized Medicaid recipients who were designated to enter skilled nursing facilities were screened to determine if they could return to the community with support services.
  - 1. Twenty-four percent of the elderly were unable to return to their homes and avoid placement in a nursing home.

2. The pilot program revealed an almost 30 percent reduction in the Medicaid costs for people receiving home health services compared to nursing home residents.

VII. Private Sector Model: Assured CarePlus Offered By North American Life And Casualty In Minneapolis

A. Benefits include long-term nursing home care, custodial care and home care, including long-term care case management services.

B. Benefit amount of $50 to $100 per day with a lifetime cap.
   1. The lifetime cap for a policy with a maximum daily benefit of $80 would be $225,000 (7.5 years) for nursing home care and $75,000 for home care.
   2. There is an emphasis on home health care as an alternative to institutional care.

C. Policies are marketed on the concept of protecting a family's assets.

Senator **Conrad**. And next we'll hear from Larry Brewster, the director of Aging Services, the North Dakota Department of Human Services in Bismarck. Larry, welcome.

STATEMENT OF LARRY BREWSTER, DIRECTOR OF AGING SERVICES, NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES, BISMARCK, ND

Mr. **Brewster**. Thank you for your invitation to appear before the committee this morning. My name is Larry Brewster. I'm the director of the Aging Services Division, Department of Human Services.

Long-term care in North Dakota has traditionally been synonymous with nursing home care. In 1983 we began a conscious change in the definition of long-term care to include home and community base services and my comments will relate to home and community base services. When North Dakota began to look at how it provided for the long-term care needs of older persons one of the things that we found is that we were very much reliant on nursing home care and institutional care to provide that long-term care.

In fact, in 1985 North Dakota was one of the highest rated States in use of institutional care for long-term care. The national average was 5 percent. In North Dakota we were slightly over 9 percent of our elderly population that were residing in institutions. So we made a conscious effort in 1983 to do two things, to strengthen our community and home base services and provide options to institutional care.

We passed home and community base service State legislation that provided State dollars to reimburse local communities for delivering home and community base services. We also received from health care financing administration a 2179 waiver that allowed the State to utilize Federal funds to provide home and community base services. I would like to say that there is an appropriate place for nursing home care and there's also an appropriate place for home and community base services.

Within this perspective I would like to simply talk about the home and community base service complement. North Dakota's home and community base service component at the present time provides services to approximately 1,400 individuals at any one time. 1,000 of those individuals are paid for by State funds in approximately 400 under our Title 19 medicaid waiver. I would like to just point out some of the important components of this program that I feel are very important as we look at Federal legislation. I would like to recommend that when Federal legislation is considered in home and community base services, that the components of North Dakota's program be considered. First, I believe it's very important to have State administration and local implementation. This provides maximum flexibility for delivery of the service and I think this is important and prior speakers have addressed this.

The second is eligibility for home and community base services should be based on functional impairment of the individual. That is the individuals capacity to meet their ongoing activities of daily living such as bathing, toileting, eating, transferring, and so forth.

The next issue is cost of the program. We believe that it is very important that service recipients share in the cost of the services they receive and we recommend a sliding fee scale in that cost sharing process.

The fourth major component of a program would be the flexibility and the types of services which may be included in the program. Should be flexible to allow for individual needs and also differences within communities.

Fifth characteristic is that the service recipients have as much choice as possible in not only the services they receive but also who they receive those services from.

The sixth characteristic is that case management needs to be the care component of the service delivery system. We need some mechanism for tying the services together. As Dr. Fickenscher has stated case management is an excellent vehicle for accomplishing that.

The seventh element is that the State should be responsible for establishing the standards and the quality assurance for the program.

And then finally an important component is preadmission screening of all applicants for nursing homes. That we do provide preadmission assessment for all applicants of nursing homes and provide them with information about options and alternatives that are available to them.

The current medicaid waiver that North Dakota has definitely responded to the needs of a large number of people. However, we find that there are a number of characteristics of the Medicaid Program that really act as barriers in utilizing the Medicaid Program as a vehicle for developing home and community base services. First is it's an administrative burden. It's very costly to administer. The second is that it uses a medical model as opposed to a functional social model. It is overly restrictive in who can receive the services. It lacks the flexibility to meet individual needs and local needs, and it also tends to direct individuals to the higher cost services as opposed to lower cost services.

[The prepared statement of Mr. Brewster follows:]

BEFORE THE
UNITED STATES SENATE BUDGET COMMITTEE

PREPARED AND SUBMITTED BY

LARRY BREWSTER, D.S.W., DIRECTOR
AGING SERVICES DIVISION, DEPARTMENT OF HUMAN SERVICES
FEBRUARY 14, 1989

Long-term care for the elderly has traditionally been viewed as nursing home care. This image in North Dakota has been undergoing a change since 1983 and now includes home and community-based services in addition to nursing home care. My testimony will focus on the home and community-based service component of the long-term care continuum.

North Dakota has made significant progress in addressing the long-term care needs of older persons through the development of home and community-based services. This effort was launched in 1983 when the State Legislature enacted legislation authorizing the Department of Human Services to reimburse County Social Service Boards for certain services provided to elderly and disabled persons who would otherwise be in need of care in an institutional (nursing home) setting. In that same year, the Department applied for and was granted a Medicaid 2176 Home and Community-Based Service Waiver for Elderly and Physically Disabled Persons.

In the last six years, considerable efforts and dollars have been directed towards developing a more balanced continuum of care along the continuum of institutional and home and community-based long-term care services. The Home and Community-Based Services Program funded solely with State dollars, referred to as the Service Payments for Elderly and Disabled (SPED) Program, has undergone numerous changes in an effort to be more responsive to the long-term care needs of older North Dakotans.

The program's current design views the long-term disability of older persons as a functional problem, a social problem, a family problem. The design of the State funded SPED Program includes:

(1) State Administration and Local Implementation -- The State is responsible for designating the case management agency, developing service standards, monitoring quality of services, developing provider standards, and evaluating program effectiveness and efficiency. County Social Service Boards at the local level are responsible for the day-to-day administration and implementation of the program.

(2) Multiple Services -- The program contains a number of different services which collectively are responsive to the long-term care (social support) needs of older persons.

These services include Homemaker, Home Health Aide, Respite Care, Chore, Case Management, Personal Care, Family Home Care, and Adult Family Foster Care.

(3) Eligibility for services is based on functional impairments which prevent people from carrying out normal activities of daily living and require needed assistance of another person.

(4) Service recipients share in the cost of the service through a sliding fee schedule.

(5) Standards for persons providing the care are competency based.

(6) The program is designed to support the efforts of the informal network (family) to provide care.

(7) The service recipient must agree to the services provided under the program.

(8) Case Management is an essential component of the program.

The SPED Program has gained broad support because it is consistent with the preferences of people--to remain at home, maintain their independence, and continue to be involved in their community to the degree their functional ability permits.

A number of barriers have been encountered in operationalizing the SPED Program. These include: (1) adequate availability of qualified caregivers on a timely basis; (2) lack of access to services in more rural areas; (3) inadequate financial resources; (4) coordination of different funding sources (Title XIX, Older Americans Act, Title XX Social Service Block Grant, State and local dollars) for services; and (5) coordination of the efforts of numerous service providers.

There is a need for Federal leadership in developing long-term care services for older persons. The direction that the long-term care delivery system must move is towards home and community-based services and away from our primary reliance on institutional care. Medicaid 2176 Home and Community-Based Service Waivers are not the complete answer to the Federal role in responsing to the long-term care needs of older persons in non-institutional settings. The 2176 Waiver has a number of negatives which are barriers. These include: impoverishment before benefits can be received; administrative burden of the program; program based on a medical model versus social model; lack of flexibility to respond to local needs; overly restrictive in who may be served; and services tend to be directed towards the more costly delivery system.

There are several proposals before Congress to address the Federal role in meeting the long-term care needs of older persons. I would encourage your support in adopting the elements contained in North Dakota's SPED Program, namely: (1) State Administration and Local Implementation; (2) eligibility based on functional impairment; (3) service recipient cost sharing through a sliding fee schedule; (4)

flexibility in types of services which may be included in the program; (5) service recipient choice in services received; (6) Case Management as the core component of the program; and (7) State responsibility for establishing standards and quality assurance.

Senator CONRAD. All right. That's an excellant outline. I really very much appreciate, Larry, the thought that has gone into what you've presented here today. Let me follow up on some of the points that you've made. You talk about State administration and local implementation. Can you flesh that out a little bit? What are we talking about when you have State administration but local implementation?

Mr. BREWSTER. The State would be responsible for such areas as identifying the case management agency at the local level for monitoring the quality of the services that would be provided for developing and establishing the standards for those service providers and evaluating program effectiveness and efficiency. Effectiveness and efficiency being cost benefit of the program plus the appropriateness of services that are delivered.

The local implementation would be that there would be some entity at the local level who would really be responsible for designing the service system at that local level and have the flexibility through needs assessments determining what services are available and then for coordinating those services and primarily that would be a case management agency at the local level.

Senator CONRAD. On the question of cost, you've said recipients need to share and it ought to be on a sliding scale basis. I assume that means according to income?

Mr BREWSTER. According to income and resources.

Senator CONRAD. All right. Let me seek to understand if there have been any analysis done on how much recipients need to share. What's the bottom end of that kind of sliding scale that you're talking about?

Mr. BREWSTER. The current home and community base service program that North Dakota has starts out the fee at about $620 per month income. So at $620 a month income for a family of one, the individual begins to pay toward a cost of the service and at that level the individual pays 10 percent of the cost, and then that scale goes up to a maximum of I believe it's about $1200 income which the person pays 100 percent of the cost. So that's our current system in how we operate under our home and community base service.

Senator CONRAD. And What is the thinking behind the need for recipients to share in the cost?

Mr. BREWSTER. Well, I think the first is that we do not have the public resources that are necessary to provide for everyone at no cost. I think the second thing is that individuals utilize the service more appropriately as they share in the cost of those services. I think it's the latter part, the investment of the individual in the services that they receive that motivates us very much to have that sliding fee scale. And the other thing is we find that people want to participate in the cost of those services if they are capable of doing so.

Senator CONRAD. And for those people who don't have the financial wherewithal but need the service, the government makes the payment, is that correct, 100 percent?

Mr. BREWSTER. Yes; that is correct. We utilize state funds for the program. So any individual that is below $600 and approximately $20 per month income, the State would pay the full cost. The average monthly cost to the State for a person under our home and community base services program is $296 a month. Many of those individuals would be in nursing homes if it was not for that service.

Senator CONRAD. Where the minimum cost would ——

Mr. BREWSTER. The minimum cost would be around $1500 a month for IC, intermediate care.

Senator CONRAD. For $300 a month versus $1500 a month?

Mr. BREWSTER. That's correct in many cases.

Senator CONRAD. Case management you've outlined as an important component. Can you describe for the committee exactly what we're talking about? Who is a case manager and what kind of decisions do they make and how do they make them?

Mr. BREWSTER. Generally a case manager is either a social worker or a nurse or a team of a social worker and nurse who has a number of responsibilities. First is to assess the needs of the individual, to determine what types of services that individual needs based on the assessment of service needs, to implement or develop a care plan, implement that care plan, to monitor that care plan and really to, as we would look at it down the road, to have a great deal of responsibility for determining where resources will be allocated to provide the care.

Now at the present time that case management agency in North Dakota is county social service agencies, but it could be a home health agency, could be a social work staff or outpatient at a hospital. Could be a number of different agencies.

Senator CONRAD. Earlier we had a doctor indicate that we ought to have control as localized as possible and another comment that there's no control anywhere, but in a perfect system his description was have the control as localized as possible. Is that the experience that I hear you sharing today that that is important?

Mr. BREWSTER. Yes; I think it's very important to have control and responsibility at the local level. Seems that when you have local control and local responsibility for the administration of programs and the implementation of programs that they are much more responsive to the needs of the people.

Senator CONRAD. Two more questions that I have and then let's open it up for the audience. Preadmission screening of all applicants, why is that important?

Mr. BREWSTER. I think that one of the reasons why persons enter nursing homes is because they are not aware of other resources and alternatives that are available to them in the community. Preadmission assessment would provide a means for assisting individuals to really take a look at what their service needs are, their long-term care needs and to look at the options and alternatives that are available to them, home and community base service options as well as the nursing home option. So it would really be to provide those kinds of options available to people before they enter nursing homes and when they consider that they do need some kind of long-term care assistance.

Senator CONRAD. My final question involves something that you said and as I understood it it related to medicare. Correct me if I'm wrong on that, you said that it directs the individual to the higher cost services, involvement in the program. Could you explain why that is so?

Mr. Brewster. Well, I think that the current Medicaid Program and I was referring to medicaid not medicare with respect to that, is that the standards through which the services are delivered are much tighter under medicaid and therefore, you would be addressing your services not to strengthen informal care givers who are family and friends that could provide the service but rather to nurses, to other higher paid staff persons. So because of the lack of real support within that program to the informal care giving system that we would find that we would be pushing towards a higher cost of service.

Senator Conrad. In other words, it's a situation that we find often where family members would like to take care of other family members but they need a break, let's say, you know, they need to be able to get out and go shopping. They need to once in a while get out and have some entertainment. They need to be able to just get away and if they don't have somebody that can give them a little relief, that forces them to take some higher level of care for that relative which is more costly and perhaps less appropriate, is that the drift?

Mr. Brewster. That's one excellent example of what I'm referring to.

Senator Conrad. Let's open it up to the audience for questions, comments that you might have of Larry Brewster. Any questions or comments?

Mr. Bakken. A.C. Bakken is my name. Mr. Brewster stated they had a medicaid waiver. Does that mean that the Federal government pays the $290 instead of the State?

Mr. Brewster. Under our waiver the average cost per recipient is $500 is opposed to our State funded program that is $296 per month. What that means is that the Federal government would pay about 60 percent of that $500 a monthly average per client. The State then would pick up the remaining 40 percent of the cost. So essentially you are correct, that the Medicaid Program picks up about 60 percent of what the cost of delivering that home and community base service is.

Senator Conrad. Others—yes, ma'am. Just identify yourself for the record. If you feel comfortable, go to the microphone.

Ms. Koch. I've been a physical therapist for 22 years in a nursing home and at one time, like I would agree with Mr. Brewster on saying that it directs medicaid patients to higher institutions because it will not pay for physical therapy in an intermediate and basic care, but it will cover it in a skilled care.

Senator Conrad. Could you explain to us intermediate and basic care? What are the differences?

Ms. Koch. Oh, gee, Lou Ann is here. Basic is where people can pretty much take care of themselves, but they are just there living because it's more of a convenience. They need supervision in taking their medicine, providing their food, and just their basic needs. Intermediate is where they require more services, oh, maybe more feeding. I think I'm going to have to call on Lou Ann for a real definition to this; but I've always said if you can give the therapy before they have to go into a skilled nursing facility, you're going to save yourself money.

Senator **Conrad**. Can you just identify yourself for the record?

Ms. **Koch**. I'm Nancy Koch, K-o-c-h.

Senator **Conrad**. Thank you very much, Nancy. Yes, Ma'am.

Ms. **Wilhite**. My name is Mary Wilhite. I realize in——

Senator **Conrad**. If you'd come to the microphone, that would help. We could hear you better. Thank you very much. If you'd help our stenographer by——

Ms. **Wilhite**. Mary Wilhite, W-i-l-h-i-t-e.

Senator **Conrad**. Thank you very much.

Ms. **Wilhite**. I have a question. Is home care available for the mentally ill or mentally retarded in North Dakota through your agency?

Mr. **Brewster**. Home and community base services through aging services that I've discussed today is available to mentally ill persons who have functional impairments.

Ms. **Wilhite**. Functional meaning physical?

Mr. **Brewster**. That means they are unable to provide care for themselves on the activity of daily living basis, so those individuals who are functionally impaired, who may also be chronically mentally ill are eligible for the services. Developmentally disabled persons are not eligible for the services through the program that I'm describing today. Because of the court order they are eligible for services under the developmental disabilities program. They have a whole different type of service delivery system.

Ms. **Wilhite**. May I ask a follow-up question on the notion of mentally ill elders. Is it perceived as a need in North Dakota that there is some kind of need for home health for—home health care for mentally ill persons? The reason I ask is because a lot of people who are mentally ill can function quite well in the community with very little professional help, very little. Somebody to supervise the medications perhaps or something as maybe twice a week with psychotherapy, something of this sort and I just wondered is that perceived as a need?

Mr. **Brewster**. I think it is perceived as a need and I think in the budgeting process through the department that there are efforts to begin to develop that type of service, companionship service and other types of service for chronically mentally ill persons; but the home and community base service program that I described would not really be in a position to provide the services that you described in your last statement.

Ms. **Wilhite**. Thank you.

Senator **Conrad**. Yes; ma'am.

Ms. **Burd**. My name is Chris Burd.

Senator **Conrad**. Chris Burd.

Ms. **Burd**. B-u-r-d.

Senator **Conrad**. Thank you.

Ms. **Burd**. In relation to what Mary had just said, the mentally ill. I'm looking at the aging population, and the subject of Alzheimer's has not come up. When you go into any given nursing home, you're going to look at 50 to 60 percent of the people living there with Alzheimer's or some form of dementia. Functionally they may be able to feed themselves, dress themselves, but they get up at all hours of the day and night, need constant supervision and that is not reimbursable in the home. So the person who needs maybe only 3 or 4 hours a day at the cost of $21 to $28 instead ends up in a skilled nursing facility for $80 a day. That's crazy, because more than half of your population in the nursing home has a dementia and that's why they predominately end up there.

What can be come about that in terms of funding people without functional disability but with a mental incapacity to maintain them at home with their care giver, spouse or family member?

Mr. **Brewster.**There are two types of functional disabilities as we call it in our assessment under the home and community base service program. The first is activities of daily living and those are generally what we refer to as functional impairments, people having difficulty transferring in and out of bed, toileting, eating, those types of things. We also have instrumental activities of daily living which are more environmental, which are need for supervision, need for transportation, cooking, meal preparation, those types of things. Under instrumental activities of daily living we do find that a number of all Alzheimer's disease victims are in fact receiving home and community base services so we try to respond to that population group.

The most frequent service that we provide to families who have a family member suffering from Alzheimer's is family home care and that is what I was referring to earlier, we cannot provide family home care or reimbursement to a family member under the medicaid waiver, but we do under our State program. So we help many families care for their Alzheimer's family member through our family home care program and that is our fastest growing component of our home and community base service program.

Senator **Conrad.** One of the things that I think we should indicate is our statistics indicate that we in North Dakota have, as I recall, the second highest number on a percentage basis of people 85 years and older who are in nursing home. As I recall, the number is 37 percent of our population that is 85 and older is in a nursing home and that is the second highest percentage in the country. And so our State is in a position to be especially affected if we could find ways to help people stay at home.

And you make a point that is, I think, really excellent and one of the most important points we ought to take away from these set of hearings that it makes very little sense not to develop a program that helps people stay at home, that helps families take care of family members who they'd like to take care of if they'd have some assistance and to force those people into institutional care which is far more costly, less appropriate place to be, and obviously taking people away from their most familiar surroundings. So I'm very pleased.

Ms. **Burd.** If I could just add to that too, just in terms of here we are the well people out here, there are about 400 people living right in this city who are institutionalized edlerly and no one is here from that group to represent themselves and put a personal face on it. The personality of some of these people and the crippling effects of taking them out of the home is not being represented here and I just want to cite the absence of these people.

Mr. **Conrad**. Well, let me just indicate to you we had a gentleman who was here, Anthony Falk, to speak for that group and he was unable to remain. He's a senior center and he was here and scheduled to provide us with some testimony and unable to remain. We do have his written testimony which is excellent and we want to publicly acknowledge our gratitude for his making the effort to be here this morning and for his written testimony, but he dod not feel well enough to remain with us.

Any other questions of Larry Brewster or comments? If not, Larry, thank you very much for really excellent testimony that I think sets out pretty clearly a set of principles that makes abundant good sense and could serve as the structure upon which to base a more ambitious program to start dealing with these problems. Thank you very, very much.

Next we will hear from Marie Feidler, representative of the American Association of Retired Persons and first thing I need to do is apologize to Mari for misspelling her name. Should be F-e-i instead of F-i-e. Have we got it right now?

Ms. **Feidler**. That's a common error, Senator.

Senator **Conrad**. Well, we apologize. Thank you very much for being with us.

STATEMENT OF MARIE FEIDLER, AMERICAN ASSOCIATION OF RETIRED PERSONS, GRAND FORKS, ND

Ms. **Feidler**. Well, thank you very much. The Association is very pleased to be able to express its views to you on the subject of the budget and long-term care and the need for improved access to care for those, for the 37 million who are not insured.

After hearing all the testimony on the needs and the costs I'm sure that it seems almost a formidable task to approach the subject and try to find the solution and it might be a temptation to actually deny that these solutions proposed are affordable. That reminds me of a statement that my father often said, that it is not whether you can do it, but do you have the will to do it. And so for our implementation of a good health care program, do the people and our leaders have the will to face up to the problem and make and continue the tradition that we American people have of having a good health program for our people.

Unfortunately I was optimistic when I came up hear and forgettable. I left my glasses in my purse which is not a good thing to do.

Senator **Conrad**. Let me indicate while she's coming back that this is the only hearing that will be out of Washington that will be before the Senate Budget Committee this year. Of course there will be hearings in Washington, but this is really a significant opportunity for rural America and specifically North Dakota to be heard from on these issues before the Senate Budget Committee renders its judgment on what we're going to do on this important subject. I did want to indicate we really have a unique opportunity here to make our voices heard. Proceed.

Ms. **Feidler**. Thank you. By a variety of measures our nations health care system is considered the best in the world, but our achievements are diminished in significance when we fail to provide both basic health care and long-term care for the millions of people who need it. We cannot deny that health care is available, the facilities are available. The industry as you know is one of the largest and fastest growing sectors of the economy.

In 1987 health care expenditures rose to over 11 percent of our GNP and they're anticipated to be 15 percent by the year 2000. The cost is great to the national government. Law makers are having to tussle with the problem, but individuals, even those who are subsidized by the government are finding the costs are high. As many of you know medicare subsidies do not cover the medical costs. The premiums are rising a percent at a time, 2 percent, 3 percent annually, and so now they are far greater than they were just a few years ago.

The part B of medicare is now the fastest growing domestic problem in the budget. In 1988 Americans paid out-of-pocket expenses of $13.4 billion for medicare's deductible and coinsurance requirements. In addition it is estimated that for every dollar beneficiaries spend on deductibility and coinsurance they spend another 50 cents to a dollar on noncoverage, service, and supplies. For the uninsured the costs are unmanageable.

So many things that I have had in mind to say have been presented to you very adequately such as a description of what long-term care involves, home care, community based care, and the facilities which are made available now to help many people who are functionally impaired. We must not forget there's also a personal cost. These functionally impaired persons are dependent on other people as well as devices and programs in order to care for themselves and to enter into daily activities.

The care givers frequently sacrifice a great deal in time, energies, and their own financial resources frequently until sometimes some of them are reduced to the same state of impairment that the people they are helping are in. Those are the people that we must not forget. The programs mentioned such as Senator Conrad so well referred to, the Resput Program which gives the care giver an opportunity to get away from the home. Frequently the care giver is also a vulnerable frail person, 70 percent statistics show are women.

To meet these drastic costs AARP strongly advocates social insurance. A comprehensive program of insurance for all people, young and old. They are considering a three-teered program that would be where the premiums, the services and all would be adapted to the ages of the very young, the working person, and the older person. Private insurance is available from some companies but as you have perhaps learned is costly and there are often restrictions which make it quite undesirable. I was hoping that Mr. Pomeroy, our commissioner on insurance, would be able to discuss this aspect more fully today, but he isn't with us.

Senator CONRAD. Maybe I could just indicate at this point that Commissioner Pomeroy was scheduled to be with us, but due to a court appearance he had to, he had to meet that obligation and there's nothing more compelling than the requirement to appear in court. Not even the United States Senate is more compelling than the requirement to appear before a judge in a legal matter, and so Commissioner Pomeroy was not able to be with us, but I thank you for that reference.

Ms. FEIDLER. The Association suggests that possible financing resources for the social insurance might be beneficiary copayments, deductibles, and premiums, payroll, estate and gift taxes, and maintenance of government spending of current long-term care programs such as medicaid. Several principles are paramount. One, the program must not add to the Federal deficit. The costs must be shared between the retired and working age population. The program must not create incentives to deliver care in a particular setting and mechanisms must be established to keep cost and use of services under control. This would make more feasible universal access to care.

There are 37 million Americans, about 18 percent of the nonelderly population who have no health insurance. About a third of this population are children. The reluctance of employers to provide coverage stems in part from rapid increases in health care. In addition to private long-term insurance programs there has been an attempt to promote employer insured or social or health insurance programs, but the problem is very complex and it does not seem to gain much of a hearing.

Basically AARP supports a comprehensive approach to the health care program. It's been fragmented by being served by many, many, many committees, many programs which duplicate, frequently duplicate one another and and fail to have a sense of direction. If that can be somehow integrated so that the various programs work together, such as was mentioned a moment ago, the home care services might save our taxpayers a fair sum of money instead of dependence upon institutional care.

One might wonder whether these costs are affordable, but one must not forget that society is paying the cost now. There's not a question of whether they are affordable or not, sometimes they're compulsory. And we should be, the society as a whole should be willing to enter into the payment of these costs, not always in dollars and cents incidentally.

Thank you, Senator Conrad, for the opportunity of presenting these statements today.

Senator CONRAD. I appreciate very much your doing so and on behalf of AARP.

[The prepared statement of Ms. Feidler follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

LONG TERM CARE AND ACCESS TO HEALTH CARE AND THEIR RELATION TO THE FEDERAL BUDGET

Presented by:

Marie Fiedler
AARP North Dakota State Legislative Committee
before the
SENATE BUDGET COMMITTEE

February 14, 1989

Good morning Mr. Chairman. My name is Marie Fiedler and I serve on AARP's North Dakota State Legislative Committee. AARP is pleased to have the opportunity to discuss the critical need for long-term care and access to basic health care for the uninsured and the challenge this presents to the federal government.

The formidable problem of the federal budget deficit, and the potential expense of providing long-term care and access for the uninsured, create a climate where it is tempting to deny that the solutions to these health care problems are affordable. However, society is already paying one way or another for the cost of care for the uninsured and for long-term care.

My remarks today will focus on health care cost concerns, how health care costs are currently borne by society, and possible options for addressing our nation's health care problems.

Health Care Cost Concerns

By a variety of measures the United States health care system is considered the best in the world. We have much to be proud of. But our nation's great achievements in health care are seriously diminished by its inability to provide access to both basic health care and long-term care for the millions of people who need it. Attempts to expand access to care and to provide a comprehensive continuum of health care services have, to a great extent, been undermined by excessive health care inflation.

For more than a decade, rising health care costs have dominated policymakers' focus on the health care system and have resulted in a variety of new provider/patient relationships and payment schemes to control health care spending. This concern with cost is understandable given the tremendous increase in health care costs that has occurred. However, emphasizing cost containment to the exclusion of other concerns, leaves both insured and uninsured patients, young and old alike, less protected and more vulnerable to the excessive costs that accompany both acute or chronic illnesses.

The health care industry is one of the largest and fastest growing sectors of the American economy. When Medicare became law in 1965, total national health care expenditures represented 6.1 percent of the gross national product (GNP). In 1987, health care expenditures had risen to over 11 percent of GNP. By the year 2000, the health care share of national spending is expected to exceed 15 percent.

In 1988, price increases for hospital and physician services grew at roughly twice the rate of general inflation, and health care costs in 1989 are expected to increase over the preceding year. It is further projected that Medicare expenditures for 1988 will approach $88 billion, an increase of about 8 percent over the 1987 spending level. Part B of Medicare is now the fastest growing domestic program of the federal budget.

These health care cost trends have translated into an increasing out-of-pocket burden for Medicare beneficiaries. The creation of Medicare in 1965 dramatically increased access to acute health care services and reduced out-of-pocket costs for this care for most elderly people. Yet today, the percentage of the elderly's income paid for out-of-pocket health costs is about the same as in 1965. The Part B premium in 1989 is $31.90 per month (including the flat Medicare Catastrophic Coverage Premium) - an increase of 91 percent since 1984.

In 1988, older Americans spent $13.4 billion on Medicare's deductible and coinsurance requirements, up 185 percent from 1980. In addition, it is estimated that for every dollar beneficiaries spend on deductibles and coinsurance for Medicare covered services and supplies, they spend another fifty cents to one dollar on non-covered services and supplies.

The Cost of Long-Term Care

For those Medicare beneficiaries who require long-term care for a chronic illness, the cost of care, whether in an institution or in the home, almost inevitably leads to an unmanageable financial burden. Medicare and private insurance combined pay only a minuscule proportion of nursing home costs (less than 3 percent in 1985) which can easily exceed $25,000 per year. Nursing home stays account for over 80 percent of the expenses incurred by older people who experience very high out-of-pocket costs for health care (over $2000 per year). Because the Medicare program covers most acute care costs, the amount older persons paid out-of-pocket for nursing home care in 1986 exceeded the amount they paid out-of-pocket that year for all hospital inpatient care, physician services, and drugs combined.

It is not generally recognized that the proportion of total nursing home costs being paid out-of-pocket has risen substantially in the last decade, i.e., from 42.7 percent in 1975 to 51.4 percent in 1985 -- an increase of about 20 percent. Thus, in absolute terms, the amount Americans were paying out-of-pocket for nursing home care rose from $4.3 billion in 1975 to $18.1 billion in 1985, an increase of 420 percent. Even when this is corrected for inflation, out-of-pocket spending for long-term care still more than doubled.

The vast majority of long-term care (71 percent) is provided in the community rather than in institutions. Medicaid, the only public program that currently funds long-term care services is strongly biased toward institutional care. Compared to expenditures for nursing homes, federal-state Medicaid spending for home health services is minute -- less than 2 percent of total expenditures. Thus, older people and their relatives are bearing the brunt of practically all the cost of community-based long-term care. Most important of all are the hidden costs of suffering, deprivation and isolation for those in our society who get no care or inadequate or substandard care.

The elderly are not alone in their need for long-term care. It is potentially needed by persons of all ages. Although demographic trends indicate an increasing need among older Americans, millions of chronically ill and disabled children and adults also need long-term care. Many of these individuals are outside of the current Medicare/OASDI system and are not covered by private insurance.

AARP advocates a social insurance approach to funding a long-term care program which would cover all those who need care, regardless of their age. Possible sources of financing include beneficiary copayments, deductibles, and premiums; payroll, estate, and gift taxes; and maintenance of government spending on current long-term care programs such as Medicaid. In evaluating various financing possibilities, we are guided by several principles. First, the program must not add to the federal deficit. Second, the costs must be shared between the retired and working-age populations. Third, the program must not create incentives for delivery of care in a particular setting. For instance, beneficiary contributions for home care should not be excessive compared to those for nursing home care. Finally, mechanisms must be established to keep cost and use of services under control.

Lack of Access to Health Insurance Coverage

Although we spend more in total, more as a percentage of the GNP, and more per capita on health care than any other country in the world, upwards of 37 million Americans (about 18 percent of the non-elderly population) have no health insurance coverage whatsoever. In 1985, nearly one-half of all non-elderly people without health insurance were workers. Among children without health insurance, 20 percent lived with a parent that reported coverage from an employer plan. The reluctance of employers to provide dependent coverage stems in part from the rapid cost increases for group health insurance.

Even though the poorest families have the greatest risk of being uninsured, they may not be eligible for Medicaid because the level of qualifying income for Medicaid benefits in many states is often much lower than the federal poverty standard. In 1984, the median level of qualifying income for Medicaid benefits was only 48 percent of the federal poverty standard. It is not surprising then that over half the children living below the federal poverty standard are not covered by Medicaid.

Possible Solutions

AARP has long supported a comprehensive approach to providing affordable health care for the people of the United States. Recognition of the need for universal access to a continuum of health care services is steadily rising. But until we muster the wisdom and political will to provide universal access to a comprehensive and coordinated system of care for all who need it, the following suggestions must suffice for progress towards the greater goal of universal access to a comprehensive continuum of health care services.

1. Fundamental to establishing universal access to health care is defining what the basic health care benefit should be. Efforts that seek to define a basic benefits package by bringing to the discussion a wide range of viewpoints represent important steps in the development of a workable plan. One such model is that developed by the Health Policy Agenda, a consortium of groups convened by the American Medical Association.

The HPA's Basic Benefits Package covers inpatient hospital care, physician and other ambulatory services, wellness care including immunizations and health screenings geared to the patient's age and history, prenatal, delivery, and total infant care, home health, mental health, and hospice services. While attention must be paid to the financing of benefits, the Basic Benefits Package is a good measure of the adequacy of health plans in both the public and private sectors, and makes a strong contribution towards defining the product to which people want universal access.

2. As an interim step towards universal access, access to needed health care services could be improved by mandating a basic health insurance plan to be provided by employers to full-time workers and their dependents. While the nation should carefully examine the problems of requiring all (save only the smallest) employers to provide coverage for their workers and dependents over the long term, mandating employers to provide benefits is an efficient mechanism to increase access to health care services in the near future. Over the long term, however, mandating benefits will not necessarily mean uniformity in protection. Some employers will be able to provide broader benefits packages. In addition, there are a variety of economic factors which could affect the comprehensiveness of coverage.

Small businesses' primary criticism of such proposals is the economic burden it puts on low-wage firms, resulting in the loss of jobs for low-wage workers. There is evidence that an increase in labor costs could result in a slight decline in employment. The magnitude of any such decline, however, will be mitigated by the smaller size cohort of workers seeking entry into the labor market due to the drop in fertility in the mid-1960's. Loss of jobs in such an environment may be less likely.

3. Access to needed health care services could be improved by expanding Medicaid to cover individuals who fall outside of employer plans. Medicaid should cover all persons under the federal poverty standard and permit uninsured persons not covered under an employer plan to buy-in to Medicaid. Seven million individuals with incomes below the poverty level and who have no health insurance at all, would be newly covered by Medicaid under this proposal.

4. Until a comprehensive, public, long-term care program can be enacted, the Association supports expanding Medicaid coverage to provide protection for low income persons who need long-term care as one method of addressing long-term care needs. The wide variability in income and asset limits for eligibility under medically needy Medicaid programs should be reduced. At a minimum, all individuals with incomes at or below 100 percent of the federal poverty line should be considered categorically needy. In addition, the federal government should require states to implement medically needy programs for all people.

CONCLUSION

What would be the impact of such programs on the federal budget? The types of programs outlined here would expand the federal budget, but they would not necessarily lead to an increase in the federal deficit if they were adequately financed. It is also important to recognize that just because the current costs of long-term care and the costs of lack of access to health care do not register in the federal budget, they are real costs to society.

The Association looks forward to working with the Congress to find realistic solutions to the health care problems faced by millions of Americans.

Senator CONRAD. I'd like to take you back to the funding sources that you had outlined that AARP would support for consideration as a basis for providing financing. Could you give us a repeat of those funding sources that AARP has indentified?

Ms. FEIDLER. Yes, beneficiary copayment premiums. In other words, having the individual pay their share of obtaining the insurance. However, premiums as we have found through the private insurance programs are high and they would require the assistance apparently of the public financing also.

Senator CONRAD. All right. Questions? Yes, sir.

Mr. LINDSAY. I want to finalize something. When you go back to Washington,——

Senator CONRAD. If you's just identify yourself again for the record to help our stenographer here keep things straight.

Mr. LINDSAY. Arnold Lindsay. When you go back to Washington, you tell the other 534 or 535 Congressmen pay no attention to the drug companies, the insurance companies, the American Medical Association, and put this thing into action. We can simplify this whole thing up this way. As far as the doctors, I respect their profession. We need them and I admire them, but let's keep them out of this thing and get us universal health. That will simplify the whole thing for the United States. You won't have to come back here and talk anymore.

Senator CONRAD. OK. Other questions or comments? Yes, sir.

Mr. WHEELER. My name is Duane Wheeler. I'm president of Wheeler Insurance, Incorporated. The last 16 years I've been specializing in medicare and long-term care and I've been listening to the comments about the affordability and lack of coverage. We have programs now that require no prior hospitalization that will pay up to $100 a day, inflation guard. We have home health, $600,000 lifetime maximum that can be bought from age zero to 84. For people from zero to 59 the annual cost is $452 a year.

The thing I say we have to do is start getting people to buy this type of protection younger. We also have companies we are coming out with specific home health care policies that will provide anywhere from $20 a day up to $160 a day for care right in your own home. So I think the insurance industry is responding. I can remember 16 years ago the maximum nursing home policy you could buy was $15 a day for 6 months that had a whopping $2700 worth of coverage. Now we're up to $600,000. So I think the insurance industry is responding and I don't think we always should depend on the Federal government to do everything for us. Thank you.

Senator CONRAD. Would you just stay there because I'd like to follow up on what you've said. I've been spending time trying to analyze various alternatives. In addition to my role as a member of the Senate Budget Committee I'm the co-chairman of the long-term care committee of the rural health caucus which has 51 Senators in the United States Senate and we are attempting to fashion an overall approach, comprehensive approach as described by our witness and clearly one part of that needs to be an insurance approach that does get people to put money aside in an earlier part of their lives to prepare for the time in which they will perhaps need these services.

We're talking about, as I described earlier, in North Dakota 37 percent of those who are 85 years of age and older in our nursing homes and you've described a set of plans that are available that people can be purchasing. Obviously we need to find ways to encourage people to do that. What thoughts do you have on how you encourage people to participate in such a plan?

Mr. WHEELER. I think the best approach to that is to give them a tax deduction for their premiums.

Senator CONRAD. OK.

Mr. WHEELER. So that they benefit in two ways by buying long-term care not only by providing their own protection but also getting a tax advantage.

Senator CONRAD. As kind of an incentive to participate?

Mr. WHEELER. Right.

Senator CONRAD. Let me ask you this, obviously there are those who are able to pay, you have mentioned a premium amount that struck in my head, for those as I recall you indicated under the age of 59 $452 a year, is that correct?

Mr. WHEELER. That's correct.

Senator CONRAD. For those who are not able to pay such an amount, I assume that would be per person?

Mr. WHEELER. Correct.

Senator CONRAD. So a couple would have a premium if they were 55 years old, a couple would pay $904 a year currently. What do you do about those people who, No. 1, are unable to make such payments or, No. 2, have failed to make such payments? Any thoughts on how you deal with those?

Mr. WHEELER. I think you'd have to go back to what the basics of insurance is. Insurance was designed to protect people's estates. If there is nothing to protect, then there is no need for insurance because we have Federally funded programs such as medicaid to take care of those situations. I think what we are trying to do is provide maximum care for everybody and I don't know that that can be done by insurance. It has to be a copartnership.

Your chart shows those that are 62 percent impoverished in 13 weeks had very small amount of assets to start with. They wouldn't have been able to afford insurance or any program and there I think the Medicaid Program has to, through taxes and through government funds, take care of those people.

Senator CONRAD. All right. Thank you very much. That was very excellent testimony.

Mr. EBERLY. May I ask a question?

Senator CONRAD. And if you'd just repeat your name.

Mr. EBERLY. I'm Vern Eberly. You mentioned that you could get policies up through 84. What would a policy for an 80-year-old man be and for how long of coverage would it be, 2 years, 1 year?

Mr. WHEELER. Premium for an 80-year-old man would be approximately $2,000 a year.

Mr. EBERLY. That would be $4,000 for a couple.

Mr. WHEELER. It would be on a 1-year basis. However, this particular company we have once you're out of the home 30 days, it reinstates itself, so you can extend that program into a 7-year program by going from the nursing home 30 days back to the nursing home. He's chuckling, but I think we should provide our health care before we're 80 years old is my interpretation. We should have something in place.

Senator CONRAD. There's no question. As a matter of social policy one thing we've got to do given what's happening to the demographics of our population, we've got an aging population. Many more people are going to need these services. We're going to have to attack the problems much earlier in life than we're currently doing.

I noticed a hand was up in back that I'd not called on. Somebody back there have a question or a comment? All right.

Ms. KOCH. I just have a question.

Senator CONRAD. If you can give your name again.

Ms. KOCH. Nancy Koch. With all the child care centers that are being somewhat subsidized by the government, has there ever been a thought that there should be adult centers for working couples to take their parents to so they can take them there at 7 in the morning and pick them up at 4 o'clock in the evening?

Senator CONRAD. Yes; former Senator Melcher of Montana had a plan that was much like the one that you've described. Unfortunately Senator Melcher was defeated in the last election. I don't think it was because of that plan.

Ms. FEIDLER. Senator, I believe we have that service in Grand Forks at Valley Memorial. There are people who go in there for day-care and are brought in by the family in the morning and picked up in the evening.

Ms. KOCH. I was thinking on an individual standing basis. I mean just like a separate building that was just made for that purpose in case the nursing homes don't provide that service.

Senator CONRAD. All right. Yes, ma'am. We'll get back to you, sir.

Ms. BLOOMQUIST. My name is Betty Bloomquist and I have a lot of colleagues here. I'm a nursing home administrator and its kind of hard not to speak today. I think there may be some misunderstandings about what goes on in nursing home care in North Dakota. For one thing, Larry will back me up, in North Dakota we have a lot of out migration of the elderly from 65 onward who then come back here in their nursing home years. So I think, you know, our reputation is fairly good. North Dakota isn't the only State, Minnesota, Montana, the States around us have high nursing home statistics. And you don't want to be in Arizona or in Texas if you're going into a nursing home. You want to be in North Dakota.

The costs may seem phenomenal but we charge at our center $2.04 an hour and that's for complete nursing care. That includes the cost of, well, in our center we provide many clothes because of donations, but we also have complete laundry service, complete food service. Our residents aren't here today and again all of us can substantiate that we're picking up where the hospitals are no longer able to provide service. Our residents are being discharged quicker and sicker. When we get residents, they are very, very often almost impossible to take care of at home. And for that reason we aren't really longterm care centers all of the time anymore. We are discharging many residents after short periods of rehabilitation.

So I guess we are with Mrs. Feidler in hoping that what we do has become part of a continuum. We now that there needs to be services that are consistent and that are, there's a spectrum of services and that we, that we're pulling together in providing all of those services.

Senator CONRAD. All right. Thank you very much for that. Yes, sir.

Mr. LINDSAY. Arnold Lindsay. I want to make a little remark on this nursing home insurance. If I was to get a policy right now, it would cost me about $1800, probably good for about 4 years. It ain't worth the paper they're written on and if I put that $1800 and everybody else that can afford it into the universal program, we'd have something for the underprivileged. It's very easy. I can pay for it. It wouldn't hurt me. I'm going to pay $3100 this year for medical insurance with my medicare, my Blue Cross Blue Shield, and my catastrophic health bill. Now these underprivileged people we've got to look out for. The only way they're going to get it is a universal bill. That's my comment on the insurance.

As far as the insurance you're never going to get insurance that's any good for the medical bill outside of universal health.

Senator CONRAD. Yes, sir.

Mr. DAHLGREN. My name is John Dahlgren. I'm with United Hospital in Grand Forks. Regarding the uninsured and the various of coverage for covering the uninsured, it costs the community less the closer you place it to the community. If you place it at the Federal level, the cost is about 5 to 7 percent of your operating budgets in hospitals. If you put that coverage at the local level, it comes to about 2 to 3 percent. The experience of bad debts and charity care in local areas of North Dakota and Minnesota is between 2 and 3 percent. If you look at the Federal level, it's betwen 5 and 7. With the budget problems at the Federal level you'd see a reduction in your medicare of about 5 to 7 percent if they covered uninsured, whereas if you leave it where it's at now, it costs about 2 to 3 percent.

Senator CONRAD. Do you have a reason for that? What's your analysis of why that is the case?

Mr. DAHLGREN. There have been several analyses of bad debts and charity care in North Dakota and Minnesota hospitals and the experience is between 2 and 3 percent. There are very, there are virtually no public hospitals here, so all the small hospitals as well as the larger hospitals take all patients. That results in some uncovered coverage for health care. Usually that ranges in the budgets between 2 and 3 percent or in the way of United Hospital slightly over a million dollars a year. If you translate that to the Federal programs, you look at the Federal history of uncovered care, we have a pretty good history in this area for payment of bills and also with financial support from Medicaid Programs and other programs.

So the resulting factor would be much more severe on the Federal level. And they would distribute that equally over the Nation as they do with medicare funds, and so you would see a reduction in your medicare funds of 5 to 7 precent in relationship to your individual hospital budget. That would be severe costs and Federal programs often result in that kind of cost. I'm in agreement that we need public support in the way of medicare and medicaid, but in the way of uncompensated care it would affect us adversely.

Senator **Conrad**. All right. Other questions or comments? Yes, ma'am.

Ms. **Keller**. I'm Mary Ann Keller. I'm with the American Diabetes Association. I'm also a board member of United Hospital. And I just want to say one thing with regards to medicare that has been a good point and that is they are finally seeing to reimburse for education of people for learning about a disease process such as diabetes and this has taken almost 10 years to accomplish because we learned if we can educate people ahead of time, we can prevent foot amputations, heart attacks, strokes, sometimes blindness and even kidney disease and I am very happy that this has come about. I have concern though for these people who have diabetes in particular because they're considered in a group of people that are called sometimes uninsurable. There are many of our insurance companies that don't insure them, so the State came out with a pooled risk health insurance plan that people like, who have diabetes or sometimes people who have terminal cancer or severe alcoholism or severe mental problems could get insurance through and we were one of only about eight States in North Dakota that had this and we were like a model for all over the country of other States trying to set up similar plans.

But now there's a bill down in the Senate in our own State that's going to make that same insurance unaffordable for these people that are using it. It's going to increase the deductibles from $150 deductible to $500 and a thousand and by the time you add the increased premium rates, it's almost going to be not available to the people anyway, so I think it's going to be wiped out. There was a time when the Federal government was looking at mandating every State to enact such a plan and that never happened, but I really think something has to be done.

Senator **Conrad**. Thank you. That's a very good point.

Ms. **Knutson**. I'm Mary Odel Knutson and I'm from the silver haired legislator in Nelson County. I understood Mrs. Feidler to say she would like to have estate and gift taxes higher. I feel we have to do more to get the people to save their money and I feel—I've never been on a Caribbean cruise. I've never been to Europe. I've worked a good deal of my life as an RN and I feel now when I have a little estate, when I'm able to give gifts, I don't feel that I should be taxed because I saved my money and not done what a lot of the other people have done.

Senator **Conrad**. OK. Other questions or comments? If not, we'll go to our next witness, Jim Opdahl, the administrator of Valley Memorial Nursing Home in Grand Forks.

Welcome, Jim, good to have you here. As with the other witnesses feel free to summarize your testimony and your full written statement will be included in the record and proceed as you wish.

STATEMENT OF JIM OPDAHL, ADMINISTRATOR, VALLEY MEMORIAL NURSING HOME, GRAND FORKS, ND

Mr. **Opdahl**. Thank you. I guess I prefer to read my testimony——

Senator **Conrad**. That's fine.

Mr. **Opdahl** [continuing]. And make some comments toward the end. My name is Jim Opdahl and I presently hold the position of President Chief Executive Officer of the Valley Memorial Home, in Grand Forks, North Dakota. We are a multi-facility organization providing a continuum of services for the elderly ranging from independently living to skilled nursing care. I thank you for this opportunity and sincerely hope that this testimony, will contribute in some way to resolve the issues we face in providing health care services to the elderly.

My testimony will address an issue which affects all aspects of health care delivery to the elderly. There are many issues which require attention as we look for ways to improve the delivery of health care service to the elderly, namely the high and increasing costs to providers, consumers, and payers of health care services, their causes and their outcomes.

However, one issue seems to stand above and encompass all others, that being the lack of a well defined coordinated and functioning health care delivery system for our elderly. By definition the health care delivery system is a networking of the many providers of health care, elderly and community services working in partnership to identify, address, and meet the health needs of the elderly. It consists of an organization operating with a common philosophy and purpose to establish the necessary direction of a plan and a process to provide the appropriate services in a cost effective and efficient manner, maximizing the choices and the options of the elderly to remain independent to the fullest extent possible.

The health care delivery system for the elderly today is quite a bit different from what I just described and what would be necessary for tomorrow. Our so-called system is many things but is not a system in the truest meaning of the word. The high and increasing costs of providing health care services is an excellent indicator or measurement of the failure or inability of our present system to respond adequately to the many changes, demands and uncertainties occurring within our environment.

Our present system is fragmented, it's ineffective, and inefficient. If we are serious about addressing the many issues we face in the delivery of health care services then we must take the necessary step to address the many shortcomings of our present system. My concern is that we will expend considerable resources in addressing the symptoms of the problem rather than address the problem itself. Our future success in providing health care services to the elderly will be directly dependent on our ability to address the problems, needs, and concerns of our present-day health system.

The truth of the matter is that you must really know or understand what makes up our present system or how it functions. I would challenge anyone to describe to me, what makes up their local health delivery system and how it functions to meet the health care needs of the elderly. I would further challenge anyone to describe to me how an elderly person or their family can enter this system, receive a comprehensive health assessment to determine their needs, find out information about services, programs, and funding sources to meet their needs, access appropriate services best suited to meet these needs and receive ongoing evaluation, referral, and follow-up services.

The aging of our population, the changing characteristics of this population, and the many problems, needs, and concerns relating to the process of addressing and meeting the health care needs of the elderly present both an opportunity as well as a challenge for us to refine our present health care delivery system for the elderly to better meet their health care needs and those of the community.

What then can be done to address this problem? I believe that the best way to address the systems issue is to begin at both ends of the health care spectrum. Government at one end and communities and providers at the other. Federal and State governments working in partnership with providers, associations and others need to develop the policy, direction, and incentives to local communities and providers to better define, coordinate, and operate their local health delivery systems. Government must recognize the need to insure their present-day health care services, programs, and funding sources will continue while at the same time establish incentives designed to encourage communities and providers of health care, elderly and community services to better organize, coordinate and operate community elder health care delivery systems. These systems will comprise the smallest organized units of the larger system serving as a base or foundation for a continuation of the networking and cooperation required for successive levels of health care system development. The emphasis here is to address the systems issue from a grassroots level allowing local communities and providers the opportunity and the flexibility to organize themselves to best meet the respective health care needs.

Governments must be careful to allow for economy and self-direction and yet insist on outcome. The role of government working closely with providers is to establish direction and the incentives necessary to encourage local communities and providers to accomplish the following: to establish an organization made up of these local providers of health care, elderly, and community services to work in partnership to achieve optimal levels of efficiency and effectiveness in meeting the health needs of older persons to the development of an elder health delivery system.

This vehicle or organization shall serve for the following purposes: to function as the hub or the center of the local elder health care system providing for a central point of entry and exit to and from the system and enhance the knowledge and understanding of the services and programs provided within the community, the environment, and the elderly themselves. Serve severance as the vehicle to facilitate and coordinate a community wide effort in planning, promotion, and networking of a continual health and lifestyle services for older persons and their families, to serve as an information, referral, resource, and educational center for older persons, their familes, service providers, and the community. Serve to coordinate and provide educational programs and transporation services. Serve to provide case management services, to meet the needs of providers and older persons and their families and serve to facilitate the networking with other elder health systems to achieve successive and continous redefinition and development of health care delivery.

The organization I just described is very similar to one which is presently functioning in the community of Grand Forks, it is called the Elder Health Center. It has come about through the initiatives of invdividuals and organizations within the community to enhance the delivery of services and programs to the elderly and better meet their health care needs and those of their familes. I believe that the future success and potential of this organization and others like it will depend on the availability of government to establish the incentives and provide the financial and other resources necessary to achieve their future growth and development. Given the time, the money, and the energy most anythig can be done.

One of the key areas in which to create incentives is to pay for case management services which are provided through organizations similar to the one described above. The role and function of case management services is evolving and will play a major role in the delivery of health care services to the elderly in the future. It can best be described as an assessment process which brings together the roles of social worker and a nurse to determine needs, develop a plan of of care, access the appropriate services, evaluation, and followup.

Case management services will be one of the most duplicated services provided within the community in the future. Providers and consumers are beginning to recognize its importance in providing health care services. Case management services are presently being provided or developed in nursing homes, home health care agencies, hospitals, social service agencies, human service centers, and senior citizen centers. Case management services is representative of a grass roots approach in creating these local elder health care delivery systems. They presently function to informally link the many services and programs within the respective institutions as well as between providers of health care, elderly and community services.

We need to focus on the development of case management services to function as the linkage we desire to establish the basic working and being building elements to these local health systems. I am very concerned about how health care services are provided. An assumption is being made that higher standards of efficiency and effectiveness are achieved through the development of systems, as it's true with health care organizations it should be also true for health care delivery systems.

An organization develops a systems approach to insure higher standards of care as well as operational efficiencies and organizational effectiveness. Organizations must reach out and work with others to continue their efforts to enhance upon their operations and service delivery health care systems must do the same. Through the development of local health care systems we will not only accomplish the development of a true system of health delivery. But we will also contribute to the overall quality of the services provided by the individual providers as well as to their operational efficiences and organizational effectiveness.

Senator CONRAD. Thank you very much, Jim. Should give him a standing ovation, don't you think? I appreciate this testimony. I think you've outlined something that really has emerged in the 2 days of this hearing and that is the very significant need for system and systemization so that people have a clear path to get information and access the system. One of the things that we found in the testimony we received, both the written testimony and the oral testimony yesterday in Fargo and some of the written testimony here today, is how much we are lacking in terms of systemization, how much we need to have a clear path and apparently you've come to that conclusion as well.

What has led you to the understanding that you've evidenced here today of the need for some kind of hub or center? I assume it's out of your experience as an administrator. Perhaps you could describe for us things that have led you to this conclusion.

Mr. OPDAHL. OK. Prior to being in Grand Forks, I've been here for about 3 years now. I've spent 4 years in the community of New Rockford, North Dakota as an administrator there. One thing I noticed in a small rural area of North Dakota as well in as a metropolitan area like this is that all the pieces to a health care system are there and they're present and they're functioning and I think they function pretty well. I think we pretty much benefit from the different parts of this system and we receive pretty good health care services.

One thing I did notice is that in a smaller community such as New Rockford there was a willingness to work together, to pull the different pieces together by most of the parties, but there still was the provincial attitude by some to function independently and to evaluate themselves and what they're doing based on what they're own needs are first and how they perceive them addressing the needs of the people they serve. The thing in the community of Grand Forks we are basically a larger small community and we have an opportunity here that all the pieces are here. In fact, we have one piece with the Elder Health Center that is also here that's representative of a vision of a number of people before I got here to try to get these pieces together to better organize and meet the needs of the elderly.

But again even it's true in this community I feel it's that all the pieces seem to function interdependent of each other if that might be a word and we work together only to the point of achieving mutual goals rather than the goals of the overall health care system. And the opportunities are there and especially with the Elder Health Center and there's a lot of people in this room today who are owners or sponsors. There's a rehab hospital, the United Hospital. I better not go on, I'll probably forget. But they're here and I just hope that we can have government provide us with the initiatives and the incentives through the case management program again so we can get an unbiased approach to addressing the needs of the elderly and referring them to the appropriate level of services.

Senator CONRAD. What is the funding source for the Elder Health Center? It's these various institutions in the community that put up the funding for it, is that the way it works?

Mr. OPDAHL. Right. It comes out of operational funds of each organization.

Senator CONRAD. And how do they determine who pays what?

Mr. OPDAHL. Well, I guess Valley Memorial Home has 18 percent, so we pay 18 percent of the budget. Others have 25 percent and I think it goes down to 3 and 5 percent, depends. So a percentage of your interest.

Senator CONRAD. A percentage based on what?

Mr. OPDAHL. A budget.

Senator CONRAD. And how do you get the various institutions to determine who pays 25 percent and who pays 5 percent?

Mr. OPDAHL. Well, I wasn't there when it was organized, but Valley Memorial Home originally only had 3 percent and since that time we've taken on 15 percent of another member and I'm not really sure. Tim Seiler is in the room. He could tell how that was originally conceived.

Mr. SEILER. We just drew a chart. Drew a big chart and threw darts. It was really kind of subjective.

Senator CONRAD. Tim, maybe you could identify for the record who you're with.

Mr. SEILER. I work with United Health Resources.

Senator CONRAD. Could you use the microphone? Maybe that would help others hear.

Mr. SEILER. I work with United Health Resources in Grand Forks and we operate an apartment place and condominium living facility. I think it was pretty subjective. We looked at all organizations and in terms of their total operating budgets and their capacity to support the project and drew it up on that basis.

Senator CONRAD. And is everyone—this is a very interesting concept. I think this is an important idea that we might take back and we should understand as well as we can how it operates because this is really the kind of coordinating device I think we're looking for. What you've done is get together because you were finding as institutions there was a lack of coordination, a lack of some centralized place to go for information, is that correct?

Mr. SEILER. Right. I think there was a number of people in the community who felt that by working together we could improve the integration and the way that elderly are able to access services in the community and a lot of it could be done through a centralized case management process that people would could work with nurses or case workers to evaluate their particular needs and appropriately place them among the continuum of different providers in the community.

Senator CONRAD. Other? Yes, sir.

Dr. OLSTONE. My name is Dr. Olstone and I'm an emergency physician. I think this is a very healthy thing that we're doing here conducting a public forum and addressing these issues. I particularly enjoyed Mr. Opdahl's comments and I'd like to see that the community and the grass roots levels are getting together and trying to solve some of these problems. I remember back in my training, which wasn't so long ago, that we take care of the sick people in the hospital and when it came time to discharge, we would draw up an elaborate discharge plan, but we would be very frustrated in knowing that this wasn't going to take place. These people were going to fall through the cracks and indeed often times they came back with their disease process out of control within a week or a couple weeks or something like that. These repeaters, if they have some kind of a long-term health plan, wouldn't necessarily fall through the cracks.

A couple comments just off the cuff. I see a lot of people in the emergency department who were brought in by their families or whatnot are very frustrated in their options so to speak for health care delivery and as a consequence end up inappropriately in my department. Often times these are social problems and not medical problems. They need to be addressed by the social system and not by a medical system. I see a continuum of health care from the hospital on down to home health care including along the way the nursing homes and that kind of thing. I think that the system is only as strong as it's weakest link. I think what we're doing here today is identifying some of those weak links and hopefully we'll be able to address those and appropriately fund them.

I'm also involved in taking care of, or helping to care for an 83-year-old woman who is functionally impaired and hopefully we can keep her in her home as long as possible. I agree with the comments of the many people who have come up here and say this is a fragmented kind of thing, people are very frustrated in trying to identify what resources they have to cope with this kind of thing. I can identify with this. I'm providing some support, taking out her garbage, buying some groceries, that kind of thing. Some other neighbors are bringing her mail in. Some neighbors bring over some food, that kind of thing. And it's a real process of love, but we all are kind of frustrated in not knowing where we can go to to find out who can help kind of coordinate these kinds of things.

So, anyway, just a couple off the cuff comments, but I think this is a really healthy kind of a situation where people are getting together and discussing these things at a grass roots level and I commend the people who put this together. Thank you.

Senator CONRAD. Thank you very much. Other comments or suggestions? Yes, sir.

Mr. NESHEIM. I have to get this over with. I wish I could tell you my name is Ralph Nader so then you'd have something to listen to. I always enjoy listening to him. I've been to these meetings.

Senator CONRAD. If you could give your name for the record.

Mr. NESHEIM. My name is Ed Nesheim. I'm from Mayville. I'm a retired dentist after 33 years in general practice and then when I lost my two brothers from cancer and heart attack, why, I went to massage school. I don't have a business. I do massage for my family and a couple friends. They don't believe in it anyway. They can't get paid for it under Blue Cross or something like that. It's got to be free.

But I've gone to these health meetings. I went to Senator Burdick in Bismarck August 17, 1987. It was held in the capitol building and I'm sure there was 130, 140 people in the audience, but none of us got a chance to give a rebuttal like this, so I certainly thank you, Senator Conrad, for opening it up. I can see why he didn't open it up to rebuttal in the audience because in Bismarck they got 245 medical doctors and there's 50, 60 of them are millionaires doing cancer surgery and open heart surgery and plastic joints, so I'm glad—I'm sure he was glad to get out and get that meeting over with.

So then I was in Fargo yesterday and it's the same thing, these witnesses, their testimonies, they sound to me like they're polished educated salesmen that work for the biggest fire department in the

United States. They want the consumer to buy this product, to keep buying fire equipment, but they do nothing with the damn arsonist that's causing this fire. That's the sickness.

There's two sides to this coin, health or medical coin shall we call it. The orthodox side of the coin, that's the medical industry, they treat sick people by surgery, radiation, and chemotherapy and their policy is protected by the Supreme Court, regulated by the FDA and they administrate their own business including their own insurance policy and we pay for it and they bury their mistakes in the cemetary and nobody asks any questions.

On the other side of the coin, that's the unorthodox care. That's the side that I'm on. Why get sick? If you eat properly, you don't get sick like we've got. It's horrible. Like Paul Harvey said or excuse me, a noted news commentator said in February 1983, page 2, the best food you can get in hospitals is only one-third the quality it should be, end quote.

Now our food is horrible. When people eat 120 pounds of sugar a year, you know, if sugar was inventored yesterday, it would be classified today as a slow poison, but it's one of the biggest businesses there is. The lobbyists in Washington, they subsidize sugar. It's the biggest profit in agriculture and the biggest junk food that comes off the earth. A guy that raises wheat and corn and barley, hell, he raises it for under cost. Now where do I go?

Senator CONRAD. You're doing pretty well.

Mr. NESHEIM. Well, like I said, I believe in chiropractics and massage and if you go to a high school, our education system, do you have a mafia in this education system? They get 60 percent of our taxpayer's dollars the way it is and they want more and they're going to use $40,000 of our taxpayer's money to have a campaign and demand more money and then when you get a home ec course in high school, they don't now what a vitamin is because I was on the board of the home ec for two years in Mayville. Never once did they talk about that.

They talk about protein, fats, and carbohydrates and as soon as that is over, you get a bundle of literature from Betty Crocker, Kraft, General Mills, Pillsbury and all those junk food corporations. They make fun of Vitamin E. It's a sex thing. I saw that once, a big diagram. I went to a course at the AC in Fargo, 2-week course. There was home ec teachers there from Alaska, Hawaii, all over the United States. When they come to talking about vitamins, they had a big sign about Vitamin E. There was a shack along the shore in the woods and that's wrong.

We eat dead foods. It's a dead—they got us believing these synthetics are the real thing and they're not. They destroy the food. When you go to a hospital, Paul Harvey was not all wrong or this commentor, when they feed you canned soup and ice cream, frozen foam with chemicals in it, and pop, you know, they're not too concerned. They just want to give you a good pat on the back. They think you were treated beautifully. And I wish, I many times wish I could get cancer so I could show people how simple it is to remedy because I go to these health conventions all over the United States. I've been doing this for 20 years. I observed nutrition when I was in the Army. I was in all kinds of camps in the Army in the United States, I was in North Africa, Italy, France, India, Burma. I was in the Himalaya mountains. There they ate organic rice. They were beautiful. No pollution. There wasn't a thing wrong. They had 32 teeth. Their eyes were perfect. Their complextion was perfect, but as soon as you get amongst this food corporations, they'll kill you.

Now I said yesterday I was going to get a remedy for this health problem we've got. The first thing I'd do, I'd put the drug peddlers, I'd put them in the stockade for 10 years. I'd never allow them to walk the streets again in our country; and then under B I'd put a thousand percent luxury tax on whiskey, pop, cigarettes, and sugar and the first license on a new automobile so we can protect the greenhouse. And then I would require that the school lunch program and the nursing homes and the senior citizen hospitals absolutely have one meal a day where 80 percent of the food is uncooked. When you cook your food, you lose your enzymes, vitamins, and trace minerals. Vitamins are practically hopeless unless you got the trace minerals. Same thing with enzymes. You can't make them synthetic. That's about it.

Senator CONRAD. Thank you very much. Well, Jim do you want to respond?

Mr. OPDAHL. No.

Senator CONRAD. All right. We should go to our next witness. Jim, thank you very much.

Mr. OPDAHL. Thank you.

Senator CONRAD. Appreciate that. And we appreciate the contributions that everybody had made here today.

Tim Burchill, the administrator of the New Rockford Nursing Home is our next witness and then we'll go on to some additional questions, additional comments from the audience and then we'll attempt to wrap it up. It's 10 to 12, so we'll be about on time. Welcome.

STATEMENT OF TIMOTHY N. BURCHILL, ADMINISTRATOR, LUTHERAN HOME OF THE GOOD SHEPHERD, NEW ROCKFORD, ND

Mr. BURCHILL. That's a pretty tough act to follow, Senator. My name is Tim Burchill. I'm the administrator of the Lutheran Home of the Good Shepherd at New Rockford. I was raised on a farm in Eastern North Dakota and I'm a graduate of Concordia College, so I'm North Dakota born and bred. I've been administrator since Jim Opdahl left to become administrator of Valley Memorial Home.

I really appreciate the opportunity to come and talk a little bit about long-term care in rural areas and when I talked to your aide, Senator, on the phone, I was asked to bring up some of the special concerns of long-term care provision in rural areas. And I wanted to tell you that the things that rural people face are very similar to the situations that are faced in urban settings as far as long-term care is concerned. However, there are some issues which are unique to the rural setting and we've heard a lot about home base services.

I guess I'm going to talk a little about the institutional side of long-term care just for a few moments. One of the biggest threats these days is the shortage of available nurses and nobody has mentioned that today. Having been in a rural area, those of you that live in rural areas, we just can't beg, borrow or steal a registered nurse these days. The way we get a registered nurse in New Rockford is if one marries a farmer or moves in as a spouse of a professional person such as a teacher or professional like that.

Senator CONRAD. Well, may I ask you this, has the community got their farmers out scouting for registered nurses?

Mr. BURCHILL. That's a good question. Maybe I need to do a little more work on that. The farmers aren't really doing that well either. This is something that's really having repercussions in rural health care facilities these days. You know, an RN can go down to St. Luke's Hospital in Fargo, work two 12-hour shifts on a weekend and get paid for 40 hours of work, and there are nurses in rural areas, I know people in Bismarck that are going to Fargo to work at large hospitals because they're in a desperate situation too and I'm not condemning them for doing it, but we can't compete with that.

In addition sun belt and, say, urban centers such as MInneapolis and Chicago are coming into the State and recruiting our nurses away from us. They can pay $20, $30 an hour in these areas which there is no hospital in North Dakota or nursing home especially that can afford to pay that.

Senator CONRAD. But then they have to live in the urban area.

Mr. BURCHILL. Right. But they don't realize that when they go.

Senator CONRAD. We should tip them off.

Mr. BURCHILL. And our quality of life is better in North Dakota, but other places have attractive things and warmer climates and it's a real problem. We need to really concentrate on showing our youth what an important and what a noble profession nursing is and it's the basis of our, of health care in our whole system.

Another thing that I would like to mention is that the things that are facing rural hospitals, the problems that face rural hospitals also greatly impact rural nursing homes because we desperately depend on the accessibility of physicians and don't let anybody kid you, there's just as bad of a physician shortage in rural North Dakota now as there was 5 or 10 years ago. There are more physicians in North Dakota but the mal-distribution problem continues.

Also it's scary. In a lot of our communities where the hospital is having trouble and financial problems and so forth, the lack of having those local acute care services available for our residents who use them so much is really a scary thing. Closure of a hospital in a community can really place medically-at-risk people in an awful situation. They need ready access to medical services.

And we also have problems especially in the more remote communities with access to specialists and more sophisticated medical equipment which is a common problem and yet the alternative of having nursing homes in rural communities where the people have lived their lives and where their families and friends are is much better than having to send them to Fargo or Grand Forks or Bismarck for long-term care. That would not be acceptable. So remoteness really does, it really does have some ominous implications for our institutionalized elderly people.

Home care has been alluded to a lot. Rural areas, the more sparsely populated, the worse the problem and I would say rural areas have a lack of noninstitutional services and if we're really going to provide that continually, we need to provide those services to all areas, rural and urban. We have some services in our community. We have home health care. We have some services that our county social service agency provides and they do a really good job, but they don't really have the resources they need to meet all the needs and I just wanted to highlight that.

The other side of that coin is that home care is not panacea. The nursing home setting is the most appropriate setting for a lot of people and somebody else has alluded today to the people being discharged from the hospital quicker and sicker. The level of care required by our residents is really getting heavier and the people that can take advantage of home services are staying home longer, which is good. There's nothing wrong with that, but the effect is that a nursing home is becoming more like a geriatric hospital would have been 20 years ago in a way.

We're providing lots of sophisticated things that hospitals only provided in the past. For one thing we have a ventilator dependent resident, one of only three in the State of North Dakota. It requires a tremendous amount of care. He's a man from New Rockford. His family is all in New Rockford. What was the alternative for him? To have him live the rest of his days at St. Luke's in Fargo and the cost of being cared for at home was three times of what it would be in the nursing home. So these are the kinds of problems that we face.

The funding issue is definitely a problem. We don't see people beating down the doors to get into the nursing home. It's kind of like being the tax commissioner, you do a job that everybody knows is necessary but nobody wants to take advantage of and we try and do our best to see that, you know, for our part of the continuum of care to see that people are in the most appropriate setting. I would say in our nursing home 95 percent of the people are there because they need to be there and family members, even if family members can help, they're often unwilling to help care for the resident in their own home, so sometimes they end up in the nursing home. I can't tell you whether being able to pay family members to provide some care in the home would have an impact, but it probably would.

I think I'll just highlight the remainder of my testimony because most of it has been covered, but the doctor from Karlstad early on in the testimony today alluded to the fact of regulation. He was on the board of a home up in Minnesota. We are regulated by so many different entities and often times they have conflicting views as to what should be taking place. They have conflicting ideas as to what is right and what is not and what's proper care and what's not and we feel really overregulated in the sense that it would be nice if the regulatory agencies could all get together and sing the same tune and this is a real problem and I think in our State we've seen, we're seeing some of that, like between the Department of Health and Department of Human Services and I commend that. We really need to see a lot more of that.

And I think we need to realize too that whenever a 60-page document outlining new requirements for homes for long-term care facilities comes out, that increases the cost and it aggravates the problem. We need to provide quality of care but we need to do it with common sense.

It's getting so that we're really in a frustrating profession and I see our nurses in long-term care facilities most of them working there because they want to work there providing so much time doing paperwork, documentation. These things are important but in the meantime the hands on patient care, resident care becomes almost secondary because of all the government regulations. We need to regulate but we need to regulate properly, we need to regulate smart and adding more regulations often just confuses the picture.

I guess that's all I wanted to share with you today. I think there are some other issues that face rural long-term care facilities and rural residents as you know. I think in Eddy County where I come from we're close to 25 percent of the population over the age of 65, so what you're talking about with the increase and the number of elderly people really hits home with us. Thank you, Senator, for the opportunity.

Senator CONRAD. Thank you.

[The prepared statement of Mr. Burchill follows:]

TESTIMONY FOR SENATE BUDGET COMMITTEE HEARING
FEBRUARY 14, 1989

Thank you for the opportunity to present testimony at this hearing. We appreciate the willingness of Senator Conrad and the Senate Budget Committee to hear our concerns regarding the provision of long-term care services in rural areas.

Rural long-term care facilities face many of the same problems faced by facilities in urban areas. However, there are some issues which are unique to the rural setting, and I will elaborate on a few of these today.

Probably one of the issues of greatest concern to the long-term care industry today is the shortage of nurses, which is a nationwide problem, but is felt most acutely in rural areas. It is a very difficult task to recruit an RN or LPN to a rural North Dakota community. The only way we get a new nurse in New Rockford is if one marries a local farmer or comes to town as the spouse of another professional person, such as a teacher. Recent North Dakota licensure requirements, coupled with the closure of several nursing schools and programs across the state, are not helping the situation. The law of supply and demand is dictating that nursing salaries increase sharply, which is good for the nursing profession, but is driving up costs at a much faster rate than reimbursement levels.

In addition, there is increasing competition between hospitals, nursing homes, and other practice settings for nurses. In general, hospitals (especially larger ones) are able to offer higher salaries, which makes recruitment by nursing homes even more difficult. In addition, there is a great deal of recruiting going on in North Dakota by out-of-state hospitals, particularly urban, eastern, and Sun Belt facilities which can often pay twice as much as we can. Therefore a large percentage of nursing graduates in North Dakota end up leaving the state for higher incomes and warmer climates.

Problems faced by rural hospitals in North Dakota also impact long-term care facilities in a significant way. Physician access is a common problem experienced by rural nursing homes. In a community with no doctor, a facility must have access to a physician or physicians in a community perhaps miles away. Or if there is only one physician in town, it often happens that most of the residents have this same doctor as their attending physician. Usually he/she will also have responsibility for a hospital and an office practice. This is a nearly impossible situation for one person to keep up with, but it happens many places in rural North Dakota.

Of course, closure of a hospital can place a long-term care facility in a precarious position because of lack of immediate access to acute care and ancillary services. This is a fear that is very real to many of us. Residents in nursing homes as a rule are medically at risk, and need ready access to medical services. Lack of access to specialists and more sophisticated medical equipment is also a common problem, due to the isolation of many communities. Transportation or lack of it is a big issue as well.

Another issue in many rural communities is the lack of access to non-institutional long-term care services. A popular goal of those involved in care and services for the elderly in this day and age is "to keep the person in their own home as long as possible". While this is a noble goal, in many rural communities these in-home services are absent, or at least very limited. If we truly wish to keep people out of the nursing home, then we need to provide services which will allow them at least an equivalent quality of care and life in their own home settings. Unfortunately, often the sparsity of the population makes the provision of such services economically unfeasible, and government has been unable to fund these types of programs to a greater extent.

Funding for long-term care services is one of the greatest problems facing not only our rural state, but the entire country. Our elderly population is growing at a steady pace, and people are living longer. Residents in long-term care facilities tend to require a higher level of care than was the case even a few years ago. New federal regulations and requirements are being imposed on providers each year. In my opinion, the high quality of long-term care which residents of our state have come to expect is in jeopardy because of a lack of dollars. Facilities are faced with a situation where salaries, supplies, and other costs continue to rise, and reimbursement mechanisms are not keeping pace. For instance, the average RN salary in the United States last year rose about 10%. The consumer price index rose something around 4%, and I can assure you that inflation in the area of medical supplies is significantly greater than that. Yet nursing homes were only allowed a 2.8% adjustment over last year's costs. Many facilities are running in the red. In fact, of the 22 facilities of under 100 beds which belong to the North Dakota Nursing Home Association, all of which are located in rural areas, a combined loss of $191,000 was shown for the first nine months of calendar 1988. No facility can run in the red and survive long. We need to be able to provide quality service to our residents. The reimbursement crisis is definitely going to be one of the great quandaries of the 1990's.

Thanks again for the opportunity to present these thoughts. I hope they have been helpful to you.

Timothy N. Burchill, Administrator
Lutheran Home of the Good Shepherd
New Rockford, North Dakota

Senator Conrad. Why don't we open it up to the audience. Because we're close to noon I assume there are some people here who are hungry. I know I am. I'm very hungry. Let me give this man a chance in the back and then we'll come to you.

Mr. Schneid. My name is Rueben Schneid and I'm a nursing home administrator also, and Tim, I appreciate your comments. I don't know who pays your bills, Betty, but the State pays us only about a $1.62 an hour for taking care of these elderly in the nursing home and that is something that is part of the whole medicaid process that takes place in the reimbursement structure, but on top of that I think the regulation thing that Tim mentioned is really critically important.

One example is the nursing shortage, licensed nursing, but what is going to become critically more important is the lack of people working as nursing assistants or what used to be called aides and orderlies. That's be coming critically important because we're at the point with our reimbursement system where we can't even pay them poverty level wages. If you look at the fact that a lot of them start out at $4 an hour, by national statistics that's borderline poverty level and a lot of them are single parent families where that's the sole income that the person probably has to provide for their own livelihood as well as the children in the family.

If we look at some of the factors that influence further costs, OBRA is not helping us one bit with the fact that, just one example is the nursing assistant training program that is required now. We've got and probably most administrators here would have people like that who would have worked in their facility for probably 10, 15 years who are excellent care givers who are frightened to death because of their level of education, mixed and wonder if they could ever accomplish the 37 hours of book learning that has to go into the new requirements for being certified and then complete written tests. And the spectrum is that probably we're going to lose a substantial number of people who are experienced nursing assistants to whom I would entrust my care and my parents' care but who will not be able to meet the requirements because of limited amounts of education, which means that we're going to be replacing these people by hiring new ones, training those people, and every new nursing assistant you hire costs you hundreds of dollars to train besides the formality of what OBRA is requiring.

Senator Conrad. Can you tell us what OBRA, what that refers to?

Mr. Schneid. Omnibus Budget Reconciliation Act passed in 1987 to which was tacked this enormous amount of stuff that INFRA has put into regulation for nursing home operations, the 60 page document that Tim was referring to. These kind of realizations that are sometimes I think, not really taken a look at realistically are some of the factors that cause the costs to really escalate to a point of it causing these kind of hearings and I think they need to be taken a look at as well as the excellent testimony of bringing together the systems to do the kind of work that we can do if we put our mind to it.

Senator Conrad. Thank you very much. Other qestions or comments? Mr. Bakken.

Mr. **Bakken**. Senator Conrad, I am pleased that you're chosen to conduct this hearing and the one in Fargo. I understand you said there were only two?

Senator **Conrad**. No, there will be a third one in Minot Thursday night.

Mr. **Bakken**. Three in the USA, all in North Dakota?

Senator **Conrad**. Three out of Washington. There will be Washington hearings as well.

Mr. **Bakken**. I guess it just verifies the statement in USA Today which I read a couple months ago that you're recognized as one of the up and coming, bright, young Senators in Washington.

Senator **Conrad**. Where did you find that?

Mr. **Bakken**. It was published.

Senator **Conrad**. I'll have to get that. They said some other things down there about me too, less flattering.

Mr. **Bakken**. Well, just a comment, perhaps, in the form of a question, but I have to summarize to lead into it. As I understand it this hearing is basically directed at long-term care for the elderly, which is, as we've heard here, much needed and growing everyday. But as most of the people in this room would know, at least the senior citizens, such as I am, that when Senator Bradley and the committee that worked up the catastrophic health bill that was approved in the last session and, you know, I guess I can say I was surprised, but I really shouldn't be by seeing letters to the editor from senior citizens and mainly senior citizens complaining that they were going to have some little additional tax taken from their social security to finance this much needed catastrophic health bill that was passed.

Their argument basically being it should be spread on the whole tax face, the whole country and there's some merit to that, but you've got to start somewhere and it seems to me it was a much needed legislation. Now I'm certainly pleased that it was passed and as I understand it, AARP has continued to support it in spite of these latecomers who have been objecting.

But in regard to the starting point, I guess every program needs a starting point. For instance social security has its starting point in July of 1935 when FDR and the Democratic party passsed the legislation, but if you're starting this now, Senator Conrad, with three hearings in Washington, I wouldn't want to hold my breath until I see any results because we've just heard in the State of the union message that by just freezing the defense budget we're going to provide something for the ecology.

In fact, Malroony was promised elimination of acid rain just this week. We're promised something for education, although it's very vague. We're promised that the drug problem is going to be eliminated completely. Now I wouldn't want to hold my breath until that happens either. And then the farmers are going to take a $2 billion reduction in subsidies, and on top of all that the taxpayers are going to pay from $40 to $50 billion to bail out the Texas and California incompetent S & L operators.

So it's interesting to attend this meeting and hear the various opinions but unless we forget this read my lips statement and get willing to support these things and get priorities straightened out, get that defense budget under control, I'm afraid it's just, you should be in Washington attending the regular session.

Senator **Conrad**. Well, we're out for this week, so I'm not missing the regular session to be here. I appreciate the sentiment though. We're on a new schedule where we're 3 weeks in Washington and we have a week to be at home for these work sessions. You've really pushed my hot button. You probably guessed you would. I would really like to talk about some of the budget priorities because this is fundamentally a question of priorities. What is society going to do? Are we going to have health care? Are we going to take care of services? Are we going to have an education system?

Let me just talk a little bit about some of the things that are in the budget that was just presented to us. I for the life of me cannot understand, first of all, you mentioned military spending. Do you know that we're spending $150 billion a year, $150 billion to pay the defense bills for Europe and Japan even though we have to borrow the money from them to do it? Now, Judge, you've made an excellent comment about priorities and when we talk about a total budget of a trillioin one hundred-sixty billion, $150 billion goes to pay their defense bills, folks, it doesn't make any sense. The budget that we've just been handed, the President suggests that this budget will freeze defense spending and freeze domestic spending on priorities like education and health care, but does anybody know here that his definition of freeze for those two different things is different? a freeze for defense spending means you freeze at last year's spending plus inflation. A freeze of spending on the health care and the education and domestic spending is a freeze at last year's spending with no inflation. So a freeze is a freeze unless it's not a freeze.

In addition to allowing inflation on military spending, but not on domestic spending, this budget actually allows real increases over inflation over for defense by taking money out of the retirement accounts which they say are overfunded for the military and shifting the funds into other operating accounts which will build the spending base for the future. And so the freeze that you've all been told about is as phony as any budget submission I've ever seen.

You talk about education. Education being given this increase, right? They talk about there going to be an increase for education. Well, there is an increase. There's more money for education than there was last year, about in line with inflation, but when you take into account the growth in those who are eligible for the programs, you're actually going to have about 100 million less for education this year on a comparable basis than last year.

Now I could go on and on. We've got a requirement that we reduce the budget deficit to $100 billion this year and this plan that's been presented to us on paper does that. But it does it by phony forecasts, forecasts for growth in the economy that are about double what the blue chip forecasters indicate will be the growth. Now we can keep going on this way until the roof caves in and that's what will happen if we keep going on this way because you can't triple the debt as we've done over the last 3 years. Triple, triple the debt. That's what we've done over the last 8 years.

And we can continue to have a bunch of phony forecasts and we can continue to play all these budget games. I know how to play them and I've been in that business before. I know how you phony up budgets and I know how you phony up forecasts. I never did it when I was tax commissioner because it'll catch up to you someday. It's going to catch up to this country someday. And everything we've talked about today that needs to be done we'll be unable to do if we haven't been honest with ourselves about what our resources are and where those resources need to go.

So, Judge, you pushed my hot button. There's nothing more frustrating to me than to be part of a process in which we kid ourselves we're not honest with ourselves and the result is the ultimate product is not honest and you're not able to address the fundamental problems facing the country and very frankly the opportunities that face the country because there are opportunities. This is a remarkable time in which we live and others are moving very aggressively to take advantage of those opportunities, in Europe and in the Far East and I'm sad to say in large measure funded by us because I recognize that what we did 40 years ago we needed to do, was a generous thing to do and it was in our own interest, but at some point it stopped being the thing to do to pay everybody else's bills and not take care of the home place.

And very frankly what we see happening in North Dakota more than any other factor, more than a farm bill, more than any other factor as a result of these larger measures that weaken the undergirding of this economy. Until we sober up as a society and say, we aren't going to take any more foolishness, we're not going to take any more phony forecasts, we're not going to take any more of this rhetoric that sounds good but means nothing, we're going to have a very hard time solving the kinds of problems we've identified here today.

Mr. BAKKEN. Who's to blame for that, the Congress, the President or both?

Senator CONRAD. I think honestly both. It's time to be honest. If we're going to be honest, both.

Mr. BAKKEN. You're young, you can straighten that out.

Senator CONRAD. Well, let me—are there other questions or suggestions that people have?

Mr. NESHEIM. I'd like to paraphrase this, our wars are much too important to leave it all up to the generals. Our health and medical is much too important to leave it up to the doctors. We should have a sick peoples Bill of Rights or let's deregulate the medical. That's number one. Number two, I've got hot rumors, real rumors that AIDS virus was purposely invented up at the World Health Organization laboratories and the big conglomerates, the big corporations, they've glad to see it happen because they're hoping it will bankrupt the medical industry. They made it by crossing a cattle virus, a sheep virus implanted on a human tissue and in less than 14 months they had AIDs Virus. The scientist from Russia, he mixed it in with smallpox vaccine, ran it to Africa and gave the villagers all these shots in the hope it will wipe out 80 million blacks so they can take over Africa and they say it was instilled in our B6 hepatitis shot, so look out.

Senator CONRAD. You had another question or comment here?

Ms. Hoverson. My name is Lynn Hoverson. I'm from Manvel, small rural area. I just had a couple comments that came at halftime. I wanted to comment like Mary Ann Keller and the fellow from Mayville, Tim, there I think I got the impression that what's needed, we need to look at more proactive methods of reducing health care costs over the long run in addition to looking at how we're going to fix the system right now. I like the idea of some of these unorthodox care issues, can't hurt might help type things that haven't been scientifically proven, but people have been using them for years and years and there's no type of reimbursement or anything going on right now, but they've been helpful in helping people keep healthy for longer periods of time. Nutrition, exercise, education, I disagree with the education being cut, the budget being cut because education is where you're going to get some of these proactive devices for cutting the health care costs. Reimbursement for nurses providing services especially in the rural areas where there is a shortage of physicians I think that is critically important in areas where there are not physicians, and nurses can and have been proven to do excellent jobs with keeping people healthy for long periods of time.

I think there needs to be more type of inventives for families and friends of persons who are functionally handicapped and want to stay home. I had two grandparents in the last 2 years who were at home and it was a real struggle for us to coordinate all the services and even when you'd call one place and try to figure out like taking the garbage out or getting the mail or helping them get to the doctor because one of them lived farther away, it was really difficult and it was a real heartache for us to try to coordinate all this. So I think the elder health center sounds like, you know working that up into a better and bigger center, that might be real helpful.

The need for the nursing homes I agree there even though people think it would be heart breaking to see family members go there. Sometimes it's really necessary. You can't keep them at home and I hate to see quality of care go down there because of shortage of nurses. I agree with the part about the nurse's aides being regulated so severely that people who have been in the health care have to get out because they can't keep up with what's strictly required of them. And above all I think we need to remember that human touch and not caring and concern. It's really easy to lose that in bureaucracy and in the system and it's important to get people in the system who really care, who have some experience, and who know what people are going through throughout the lifetime continuum. Thanks.

Senator Conrad. Thank you very much. We've got time for one more comment. Yes, ma'am.

Ms. Nelson. I'm Sherry Nelson. I'm with Home Health Agency here in Grand Forks. I think one of the things I've heard today and there have been some excellent comments made, Dr. Fickenscher, Mr. Bunnell, and of course I'm prejudice in favor of home care. But I think what we have to look at is that there are appropriate levels of care that are needed. In the acute care hospitals hospitals we have three levels usually within the nursing and institutional programs. We have home care, everything from the very high tech right down to the personal care services, taking out the trash and helping someone get to and from a physician.

Perhaps one of the things we need to do is separate social needs from health, clinical health needs. I get calls as a home health director from people who need services and the need is definitely there. It does impact their health, but it is not a medical need for care. The emergency room physician spoke to the same thing, the people who end up in his emergency room because there is no one else to go to and there is no place else to go to.

The two portions overlap a lot or they coordinate a lot, but they're not the same. Providing care to an individual in a basic care facility should not have to meet the requirements that you deal with in trying to provide medical care to someone in a skilled nursing facility. Medicare certified home health agencies who are caring for high tech types of patients end up being caught in having to do the same amount of paperwork, the same type of billing, everything else. When they're caring for someone who really needs just supportive care, someone to supervise medications once a week and making sure they're taking them and they're working right, if we take the whole thing and lump it together. So first of all, if we can make that separation and get the appropriate people doing the jobs in the social area and the appropriate people doing the job in the more clinically related areas.

I think the second issue, Mr. Burchill addressed it and several others, are the costs incurred simply by being part of a Federal program. Our average time for a visit and this is in a skilled care program is 2.01 hours. Of that time approximately 60 minutes of it is spent in direct hands on care with that patient, an average of 14 minutes is spent in travel to and from the patient's home. Another 16 minutes is spent usually in coordinating services, instructions to an aide, contacting a physician. The balance of the time is spent in filling out medicare forms and the documentation that is required.

We currently have forms and documentation that take approximately an hour and a half to complete just to admit a patient to service. That doesn't count the time you spend taking care of them, of giving an I.V. man, of changing a dressing or anything else. It's filling out the forms. I had a surveyor from my medicare survey last year. She was there for 4 days, approximately 10 to 11 hours a day. And I know every nursing home administrator in this place can relate to it. In that length of time she found two major problems, one, a failure to have a doctor's order when we decreased visits because the patient was doing so well, which we thought was appropriate utilization; and the second one was the failure of an RN to sign off on a nurse's aide instruction sheet.

This is the type of thing we're dealing with as soon as we start dealing with federally and at least federally mandated programs. I think we have to be careful of what we ask for. If we want Federal Government to do it all, we may have to pay the consequences, and second, if we want to pay for it, we have to look at how much the cost of administration takes as opposed to what actually goes to the individuals who receive that care.

Senator CONRAD. Thank you very much. I'm sorry, we're going to have to close it off. We indicated that would be the last and we'll hold to that. If anybody else has additional testimony that they'd like to submit, we'll hold the record open for 2 weeks, so additional testimony could be submitted. I want to thank all of you for participating. I especially want to thank those who were witnesses and those who came up out of the audience to provide their views and experiences. That's very helpful to us.

We'll end this series of hearings in minot on Thursday night with a hearing on the urban rural differential, and that will be a hearing that will go from 6:30 in the evening until 9:30 Thursday night. So again I thank all of you for coming out. We appreciate it and we'll look forward to working with you in the future. Thank you very much.

[Whereupon, the above proceedings were concluded at 12:30 p.m.]

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
STATE CAPITOL
BISMARCK, NORTH DAKOTA 58505

NORTH DAKOTA
DEPARTMENT OF HUMAN SERVICES
John A. Graham, Executive Director

NORTH DAKOTA
CENTENNIAL
George A. Sinner, Governor

February 10, 1989

Senator Kent Conrad
United States Senate
Washington, D.C. 20510

Dear Senator Conrad:

Thank you for the opportunity to provide input in regard to the crisis in rural health care.

I wish to express a very specific concern in regard to the effect upon the State of the Nursing Home Reform Section of OBRA '87, as interpreted through draft guidelines published by the Health Care Financing Administration.

As you may be aware, states were required to institute the "preadmission assessment with annual resident review" (PASARR) process on January 1, 1989, despite the fact that HCFA has issued no regulations. We have been encouraged to use the draft standards developed by HCFA in designing our State's process. The draft Standards, which have not been subject to public comment since they have not been published as proposed regulations in the Federal Register, have effectively taken well-intentioned legislation and converted it into a bureaucratic maze which is costly to the states and potentially very detrimental to mentally ill and mentally retarded citizens who are in need of nursing facility care. The criteria states specifically that "any person with MI or MR determined through the PASARR process to be in need of active treatment services shall be considered inappropriate for placement or continued residence in a Medicaid certified nursing facility." The only exceptions made are for 120 day convalescent placement, terminal illness if the person's life expectancy is less than six months, comatose condition, and a few other serious illnesses. For a rural state such as ours, the alternative placement options are very limited, primarily institutional care at Grafton State School or the State Hospital, both of which we are currently attempting to depopulate.

North Dakota has not routinely warehoused mentally ill or mentally retarded in nursing homes. We have, however, considered nursing home placement a feasible option for individuals whose physical condition requires nursing level care, as long as their

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AFDC	224-2332
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Food Stamps	224-2328
Fuel Assistance	224-2086
Medical Assistance	224-2321
EXECUTIVE OFFICE	(701) 224-2538
OFFICE OF VOCATIONAL REHABILITATION	(701) 224-2907 Voice 224-2699 (TDD)

GOVERNOR'S COUNCIL ON HUMAN RESOURCES	(701) 224-2970
OFFICE OF MANAGERIAL SUPPORT	(701) 224-2538
Legal Services	224-2311
Management Services	224-2306
Personnel	224-2336

OFFICE OF FIELD SERVICES & PROGRAM DEVELOPMENT	(701) 224-2316
Aging	224-2577
Alcohol and Drug	224-2769
Children and Family	224-2316
Crippled Children	224-2436
Developmental Disabilities	224-2768
Mental Health	224-2766
Volunteer Services	224-4777
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TOLL FREE	(800) 472-2622

active treatment needs could be handled. HCFA criteria intend to destroy this option. As quoted in the February 2, 1989, issue of the New York Times, "the 1987 law either shoves people onto the street or into boarding homes, or into mental hospitals....Nursing homes may not always provide what's most appropriate for the mentally ill, but why take them out and make them homeless?"

I urge that you delay the continued implementation of the legislation until such time as HCFA publishes regulations. To do otherwise places the State in the untenable position of implementing a cumbersome, illogical, and confusing process in order to avoid severe fiscal penalties.

I would be more than happy to provide further specific information at your request.

Sincerely,

John A. Graham

John Graham, Executive Director
Department of Human Services

bd
c: Yvonne Smith
   Cabinet

THE URBAN DIFFERENTIAL

THURSDAY, FEBRUARY 16, 1989

U.S. SENATE,
COMMITTEE ON THE BUDGET,
Minot, ND.

The committee met, pursuant to notice, at 6:36 p.m., in the Norse room, International Inn, 1505 North Broadway, Minot, ND, Hon. Kent Conrad, presiding.

Present: Senator Conrad.

Staff present: Gorman King, Counsel and Legislative Assistant.

OPENING STATEMENT OF SENATOR CONRAD

Senator CONRAD. Why don't we begin so that we get started on time and hopefully end on time.

I am Senator Kent Conrad. I want to welcome you and tell you this is an official hearing before the Senate Budget Committee. That means that the record that is established here tonight will become part of the record upon which the budget committee bases its deliberations this year on the question of health care costs, medicare budgeting, and other matters that may arise at this hearing that reflect on budget issues.

In this series of hearings, we've met in Fargo, ND, on the questions of soaring health care costs and the problems of the uninsured. There we learned that health care costs are projected to double by 1995, to triple by the year 2000. And at the same time, there are tremendous unmet needs, with 37 million people in this country uninsured, millions more underinsured, and a growing social problem that cries out for redress.

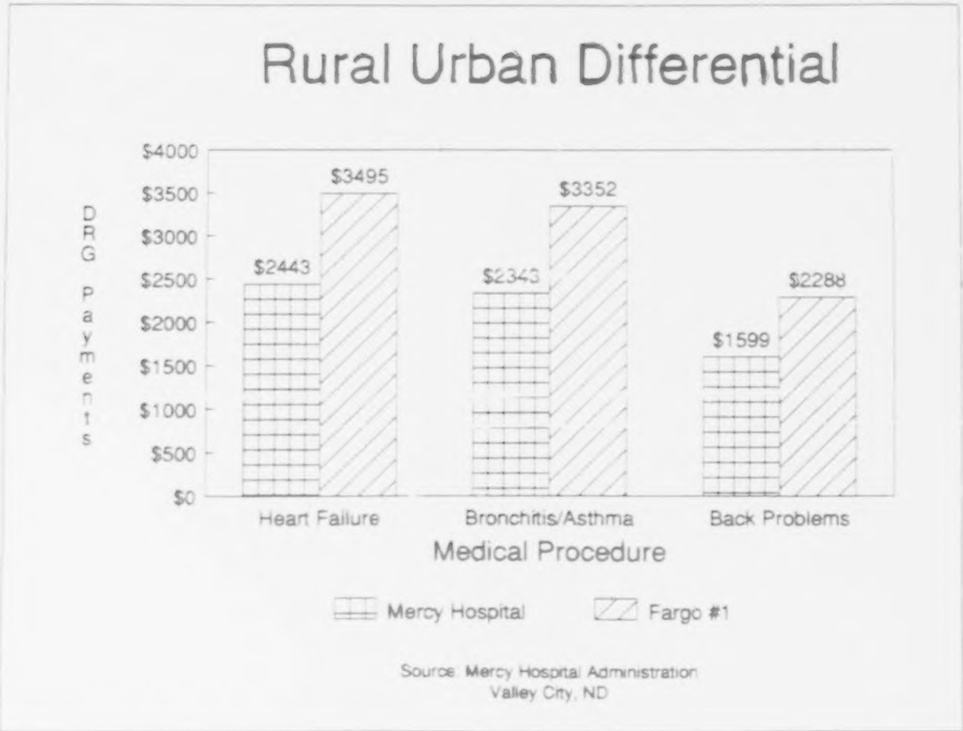
Tuesday in Grand Forks, we had a hearing on long-term care. And in that long-term care hearing, we learned that just 13 weeks in a nursing home would impoverish 60 percent of singles who required long-term care treatment in a nursing home setting.

We also learned in this set of hearings that of the uninsured in North Dakota—and there are some seventy to eighty thousand uninsured in North Dakota—fully 78 percent of those are employed. So the stereotype and the notion, that many of us have, that those who do not have insurance are those without jobs is simply not correct. The vast majority do have jobs. And this is a problem that is becoming even more serious.

Tonight, we are here to talk about the question of the urban-rural differential. We all know that hospitals are vital to our economy, and rural hospitals in particular, and often the largest employers in their communities, and are the sole source of health care for surrounding residents. And these hospitals are facing some serious challenges in the delivery of health care. They and our rural economies are endangered by inequitable medicare reimbursement, which now constitutes a large percentage of their income. In this time of budget deficits, medicare is a chief target for budget cutters. Indeed, President Bush has prepared a cut in the medicare budget of over $5 billion. That's medicare and medicaid. So despite the current inequities, medicare is facing proposals for drastic cuts.

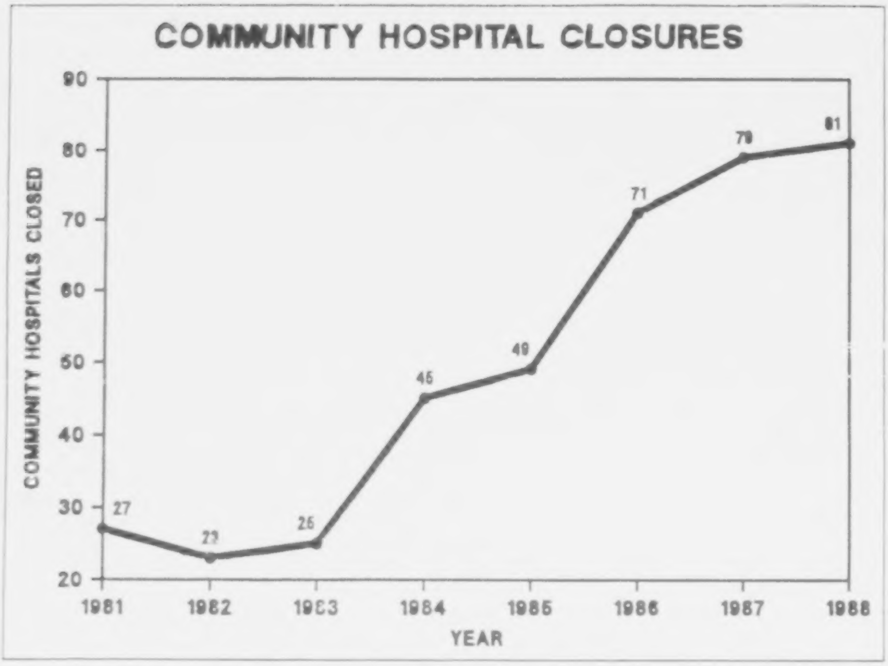
I'd like to direct your attention to the first chart, which shows the urban-rural differential for various medical treatments. This is based on a study that was done by Mercy Hospital of Valley City, and it shows, in comparison to a hospital in Fargo, what the hospital in Valley City would get for reimbursement from medicare. And you can see on a heart failure and shock case, Mercy Hospital in Valley City could expect to get about $2,400; the hospital in Fargo, almost $3,500. For bronchitis and asthma, the hospital in Valley City could expect to get about $2,300; the hospital in Fargo, $3,350. And on a medical case that involved back problems, Mercy Hospital in Valley City would get a reimbursement of $1,600, while the hospital in Fargo would get almost $2,300. It's that kind of differential which we are referring to.

And to put this all in context, rural hospitals are under increasing pressure as a result of that kind of differential. Since 1981, fully 160 rural community hospitals across the Nation have closed. Six hundred more stand at the brink of closure. Of the hospitals that lost money in each of the years from 1984 to 1986, 83 percent were rural hospitals. The recent national survey of rural residents found that rural hospitals are often their community's sole health care providers, and that in fact rural hospitals account for an average of 25 percent of the economic activity of the community in which they're located.



Source: Mercy Hospital Administration
Valley City, ND

Next, I'd like to just briefly draw your attention to this second chart. And this will be the last one, and then we'll get into the testimony, because I'm here to listen more than talk. This chart shows what's happening with community hospital closures across the country from 1981 through 1988. And you can see the trend line. It speaks for itself. In 1981, there were 27 community hospital closures. That has skyrocketed to 81 in 1988, a three-fold increase in just 7 years.



That is the challenge that we face in rural America, and it's the reason that we have held this hearing—budget committee hearing in Minot this evening.

And tonight we will be hearing from a distinguished group of witnesses, and we will start with Wally Strauch, the president of St. Joseph's Hospital in Minot. Welcome, Wally.

I want to just indicate, for the benefit of all witnesses, that the way we will proceed will be under the rules of the Senate Budget Committee. And that means simply this: That witnesses will be asked to summarize their testimony; their full written statement will be made part of the record. We will leave the record open for 2 weeks after the close of this hearing for any additional testimony that people might want to provide or any corrections to their testimony. In addition, when we get to the public comment part of this hearing and people are free to go to the microphone, identify themselves and provide their testimony, and we will also leave the record open for them to provide testimony.

Let me indicate one further rule, and that is we are operating under the official rules of the Senate Budget Committee, so this hearing will be conducted just as if we were in Washington in the hearing room of the Senate Budget Committee. And that means I will rule out of order anybody who speaks out of turn or attempts to demonstrate in disagreement with somebody else's testimony. Obviously, we're glad to hear differing points of view, but we want to make sure that everybody has a right to express their point of view. And so we will adhere to those rules.

[The prepared statement of Senator Conrad follows:]

Senator Kent Conrad
Opening Statement
Senate Budget Committee Hearing
"Medicare and the Crisis in Rural Hospitals"
February 16, 1989
Minot, ND

Good evening. Thank you for coming out tonight to attend this Senate Budget Committee hearing on health care. Across the state of North Dakota this week, the Senate Budget Committee has been investigating the state of health care. On Monday, February 13, in Fargo, we discussed Medical Costs and the Uninsured. On Tuesday, in Grand Forks, we considered the need for Long term Care. And tonight, we intend to examine the Medicare system and the plight of rural hospitals.

INTRODUCTION

Today we shall examine the Medicare system. It is a complex one, one that has seen many changes since 1980. Medicare is the largest source of income for many hospitals. The dramatic changes in Medicare that were established in 1983, then, have had a profound effect on hospitals; rural hospitals, in particular, which are the mainstays of their communities, have encountered declining Medicare reimbursement due to the Prospective Payment System.

BACKGROUND AND HISTORY OF MEDICARE

As you know, Medicare provides health insurance protection for 33 million aged and disabled individuals and accounts for about 8% of the federal budget. Fiscal year 1988 Medicare outlays are estimated to be $84 billion. Congress has expressed concern over the dramatic rise of Medicare expenditures, which have grown faster than health expenditures in general, and over the financial condition of Medicare's Hospital Insurance Trust Fund which under current policy could be depleted in 2005.

Since 1983, Medicare payments to hospitals for inpatient services have been made according to a prospective payment system (PPS). Under this system, each Medicare patient is classified into one of 474 diagnosis-related groups (DRGs) according to his or her medical condition. Hospitals are paid a predetermined rate for each patient treated within a given DRG. Hospitals with costs below the payment rate are allowed to keep the surplus, while hospitals with costs above the payment rates must absorb the loss.

PPS is intended to encourage hospitals to find ways to reduce costs of inpatient treatment. Payments are adjusted to allow for differences in local market conditions and other circumstances which may affect they level of cost per discharge. This is the basis of the different DRG payment rates for urban and rural hospitals. Hospitals also receive additional payments to help defray the extra costs of operating special programs (i.e. graduate medical programs). Some other hospitals, such as those that are the sole source of inpatient care in an area, and referral hospitals, also receive special treatment under the PPS system.

The concept for PPS is a good one. In fact, hospitals have reduced their lengths of stay, increased productivity, and reduced staff levels. But the PPS system has seriously jeopardized the future of rural hospitals.

RURAL HOSPITALS IN NEED: THE URBAN/RURAL DIFFERENTIAL

Hospitals are vital to our economy. Rural hospitals, in particular, are often the largest employers in their communities, and are the sole source of health care for surrounding residents. These hospitals face awesome challenges in the delivery of health care. They, and our rural economies, are endangered by inequitable Medicare reimbursement, which constitutes a large percentage of their income.

Medicare payments to rural hospitals average 14.5% less than those to urban hospitals. The average small rural hospital (fewer than fifty beds) suffers a loss when caring for

Medicare patients. Based on information the Mercy Hospital of Valley City has provided, we can see the effects of the differential. [see chart]

Since 1981, 161 rural community hospitals across the nation have closed; 600 more stand at the brink of closure. Without adequate Medicare reimbursement, rural hospitals find it difficult to survive. PPS has meant that many rural hospitals operate at a loss. Of the hospitals that lost money in each of every year for the first three years of PPS (1984-1986), 83 percent were rural hospitals. Of those hospitals, more than half had fewer than 50 beds.

The solution to these problems is a complex one. Clearly, one national payment rate for Medicare should be adopted. This may be a costly proposition, considering our current budget situation. Urban hospitals, too, fear that a single national rate would spell much lower reimbursement for their hospitals. However, estimates indicate that if a single payment rate were adopted for both urban and rural hospitals, income for rural hospitals would increase approximately 11.5%, while payments to urban hospitals would decrease 1.6%.

RURAL HOSPITALS: A VITAL COMMUNITY COMPONENT

A recent national survey of rural residents found that rural hospitals are often their community's sole health care providers. The survey found that, largely because of limited resources and access to transportation, only 31% of those under age 75 crossed a county line to obtain care. Further, only 18% of those over 75 left their home counties for care.

Yet, despite their importance, community hospitals constantly face the threat of closure. The American Hospital Association has found that an escalating and alarming number of community hospitals face closure.

Rural communities also face severe shortages of nurses and doctors. Partly due to poor Medicare reimbursement, many rural hospitals are struggling to survive, and thus have difficulty attracting and keeping skilled medical professionals. The Department of Health and Human Services Nursing Commission estimated that 9% of rural hospitals were forced to close beds as a direct result of the nurse shortage.

Rural areas have difficulty attracting doctors to rural areas also. It is not unusual for local governments, businesses and hospitals to offer physicians willing to relocate financial bonuses and annual guaranteed annual incomes for one or more years until he or she can develop a financially viable practice. Of course, physicians willing to consider rural practice often find it difficult to develop an economically successful practice in rural settings. Because of lower population density, lower Medicare reimbursement, lower private insurance reimbursement, and the fact that fewer rural residents have health insurance, rural physicians face the prospect of working longer hours simply to maintain a financially viable practice.

Medicare Budget: Soaring Outlays

Furthermore, despite current inequities in the Medicare system, it is a likely target of budget cutters. Medicare outlays continue to climb at a rapid rate, with expenditures expected to top $100 billion this year. If these trends continue, the Medicare budget will exceed the defense budget or the Social Security budget by the year 2005. Thus, our country is not in a strong position economically to step in and correct current Medicare imbalances.

CONCLUSION

We face tough choices -- floundering rural hospitals, escalating health care costs, increasing outlays for Medicare -- all this with the tight fiscal situation that is mandated by our twin budget and trade deficits -- this is a recipe for disaster.

Rural America, faces special challenges. Unemployment, underemployment, poverty, and outmigration are increasingly serious problems in nonmetropolitan counties throughout the nation. The crisis was prompted by a severe agricultural recession and sharp decline in agricultural input industries, from which many parts of the country have not yet recovered. Increasing global competition has crippled rural areas, which lag behind in the technological innovation required to compete in a new global economy. Simultaneously, rural areas have faced declining support from the federal government.

Revitalizing the rural economy must be a high priority in the 101st Congress, and I believe this requires a comprehensive approach. Improving health care must be an integral component of any rural development package.

The plight of those people and institutions who provide the all important service of health care in rural areas is indeed alarming. Today we will hear from those who experience this crisis first hand. We will hear their stories and their suggested solutions.

Senator CONRAD. With that, welcome, Wally. Very much appreciate your participation. Feel free to proceed.

STATEMENT OF WALTER A. STRAUCH, PRESIDENT AND CHIEF EXECUTIVE OFFICER, ST. JOSEPH'S HOSPITAL, MINOT, ND

Mr. STRAUCH. Thank you, Senator Conrad. My name is Walter Strauch, president and chief execultive officer at St. Joseph's Hospital located here in Minot.

We are a 172-bed community hospital which has served north central and northwestern North Dakota since 1911. I would like to extend the appreciation of the Sisters of St. Francis, our sponsors, and our board of directors for allowing us this opportunity to present this testimony to the Senate Budget Committee.

As a frame of reference, I would indicate the operating budget at St. Joseph's during this current fiscal year is $21.5 million. We employ 535 people from Minot and the surrounding communities. And the hospital has had a long history of providing some particularly unique services to this part of the State. Namely, an inpatient, 30-bed psychiatric unit, which was begun in the late 1960's. We have also, since the early 1970's, provided a chemical dependency program, and in 1982 opened a new 20-bed inpatient facility. Additionally, we serve as the cancer therapy center for this region of the State, having upgraded our capabilities in 1984 with the installation of a linear accelerator. We also provide an extensive range of medical and surgical and obstetrical services.

Senator, you have asked us to particularly address at this hearing the medicare program and its impact on rural hospitals. Certainly a major concern of hospitals generally, and I speak for St. Joseph's individually, has been the failure of the Government, we feel, to live up to a major promise of the Prospective Payment System to provide, on an annual basis, increases in payments equivalent to the hospital market basket cost increases.

As you know, during the 6 years of PPS, the hospital market basket has increased 28 percent, roughly 4½ percent a year. However, congressional PPS updates to the hospitals have totaled just under 15 percent, or about 2½ percent a year. The last 4 years of increases authorized by Congress have only been 6.4 percent, or about 1½ percent a year.

The cumulative shortfall to St. Joseph's Hospital over this 6-year PPS period is in excess of $2.2 million, with $1.2 million of that shortfall coming in just the last 2 years. Our inpatient DRG discounts have increased from $2 million a year to $4 million in just the last 3 years. Changes in outpatient reimbursement have also taken its reimbursement toll in the last few years. Our outpatient medicare discounts have increased from $390,000 in fiscal year 1986 to $650,000 in fiscal year 1988. Adding both our inpatient and outpatient DRG discounts for that 3-year fiscal period results in a total medicare discounted dollar amount of $10,700,000. During our last fiscal year, medicare beneficiaries accounted for 40 percent, or approximately 2,000, of our inpatient admissions and about 45 percent of the hospital's revenue.

The question that is certainly to be raised, as this information is presented, is to what extent does the hospital address the issue of cost containment. Two years ago, our overall expense increase was approximately 7 percent. Last fiscal year, we reduced that to 6 percent. And based on the pace of our expenses this year, we predict an overall expense increase of less than 4 percent. We are currently operating with 60 less employees than we did when the PPS system started.

At the same time, we felt it necessary to add a number of services to address the needs of the people in our area. We are pleased, Senator, that you had the opportunity today to visit one of those newly added services, our community hospice. We have also added a vital outpatient partial care service for our mentally ill patients. We have greatly expanded our day surgery program that admits and discharges surgical patients on the same day. A vast majority of these cases previously were 2- and 3-day hospital stays. Thirty-six percent of those cases handled in our day surgery program were medicare patients. We have expanded our outpatient services for the chemically-dependent patients in an effort to treat those people who may not need the more intensive, expensive inpatient services. We have added an educational—advice and education program for senior citizens in our service area. We have worked in concert with the local chapter of the Mental Health Association and the North Central Human Service Center. This cooperative effort has resulted in the joint development of a psychosocial center, a social club for the mentally ill.

Within the last 2 years, we have developed a foundation to assist us in raising funds for essential services and new services we feel are needed in our community. We feel, however, this should not negate the Government's obligation to reimburse us fairly for the services we provide.

The medicare program initially recognized its responsibilities in assisting hospitals by paying their fair share of depreciation expense incurred by the hospitals. The medicare program has already cut 15 percent of its fair share of the hospital's depreciation expense. This represents a $100,000 annual decrease in payments the hospital should receive. The proposed fiscal year 1990 budget from the Government would increase that shortfall by another 10 percent, decreasing medicare's equitable share of that expense by a total of $170,000 a year.

St. Joseph's recognizes that the Medicare Program has made a commitment to the senior citizens of this country, and we have made every effort to be responsive to the needs and the expectations of the medicare-eligible people we serve. We feel fortunate to have received the rural referral center designation at the start of the Prospective Payment System. Had we not received that designation, we would be receiving annually $500,000 less than we currently receive. At the same time, we receive about $500,000 less than the hospitals located in Fargo, Grand Forks, and Bismarck.

I mention this example only to relate to you one of the distinctions—some of the distinctions that exist in the system, and would suggest that further efforts on the part of the Medicare Program to realign categories and designations of hospitals only compounds the problem. We do not believe it is fair to take what is now a 6-year period of underfunding and begin shuffling those dollars from one group of designated hospitals and passing it along to another group in an effort to provide quick fixes to the total hospital service system.

I feel there needs to be an extensive reevaluation of the DRG system, and in the meantime would strongly encourage the continuing Band-Aid fixes be curtailed and that Congress acknowledge their original commitment to the hospitals of this country to fully fund market basket increases.

Thank you for this opportunity to present St. Joseph's concerns to you this evening.

Senator CONRAD. Thank you very much. Wally, if you would stay there just for 1 minute so I might ask a question. Your hospital operates as a rural referral center; is that correct?

Mr. STRAUCH. Yes, it does.

Senator CONRAD. Clearly, there would be advantages to that. Are there disadvantages?

Mr. STRAUCH. I guess generally the major disadvantage is that, as I noted, we also fell just short of reaching an urban designation, which——

Senator CONRAD. By what amount did we——

Mr. STRAUCH [continuing]. That equates to about another—how did we miss the urban?

Senator CONRAD. Yes.

Mr. STRAUCH. It's basically a question of population base of the major metropolitan area that we are located in, and Minot fell, was it 10,000 or something, short of meeting that requirement for a population base where the hospitals are located.

Senator CONRAD. Have you analyzed how much difference that would make to you?

Mr. STRAUCH. If we received the urban rate, it would be an additional $500,000 a year for basically the same population that we would serve.

Senator CONRAD. All right. Why don't we proceed. Thank you very much, Wally. Very much appreciate your taking the time to participate with us this evening.

[The prepared statement of Mr. Strauch follows:]

U.S. Senate Budget Hearing

Minot, North Dakota

February 16, 1989

Presentation Submitted by: Walter A. Strauch, President,

St. Joseph's Hospital, Minot, ND

Introduction: Senator Conrad, my name is Walter Strauch, President and Chief Executive Officer of St. Joseph's Hospital located here in Minot. St. Joseph's is a 172-bed community hospital which has served Minot and north central and northwestern North Dakota since 1911. May I extend the appreciation of the Sister of St. Francis, our sponsors, and our Board of Directors for allowing us this opportunity to present this testimony for the Senate Budget Committee. We are also grateful for the efforts made by Congress at the start of the prospective payment system, and particularly to our North Dakota congressional delegation, for their work in recognizing the unique position of rural referral centers such as the two hospitals here in Minot. We feel that the rural referral designation was justifiably given to our facility, Approximately 50% of our patient load comes from Ward County, and the other 50% from the north central and northwestern North Dakota counties, a service area of about 110,000 people.

As a frame of reference, I would indicate the operating budget at St. Joseph's Hospital during this current fiscal year is $21.5 Million. St. Joseph's employs 535 people from Minot and surrounding communities. The hospital has had a long history of providing some particularly unique services to this part of the state, namely an inpatient 30-bed psychiatric unit, a service that was begun in the late 1960's. We have also, since the early

1970's, provided chemical dependency services and in 1982 opened a new 20-bed inpatient facility. Additionally we serve as the cancer therapy center for this region of the state, having upgraded our capabilities in 1984 with the installation of a linear accelerator. In addition to these particularly unique services, we provide an extensive range of medical and surgical services.

Senator Conrad, you asked us at this particular hearing to address specifically the Medicare program and its impact on rural hospitals. From the very beginning of the Medicare program in the mid 60's, the commitment of the Federal government to its senior citizens was that they had the right to expect equal access to health care, such access to include the latest in medical technology and treatment modalities. By the early 1980's, most health care providers had come to the realization that the cost reimbursement system under which the Medicare program began was perhaps spiralling out of control and was ready for a major change - enter the prospective payment system which I feel generally had the endorsement of those of us from hospitals.

But certainly a major concern of hospitals generally, and I can speak for St. Joseph's individually, has been the failure of the government to live up to a major promise of the PPS system to provide on an annual basis, at least increases equivalent to the hospital market basket increases in costs. As you know, during the first six years of PPS the hospital market basket has increased 28%, roughly 4 1/2% per year, whereas the congressional PPS updates have totaled just under 15% or approximately 2 1/2% per year. If you exclude the first two years of PPS when the authorized market basket increases were somewhat higher, the last four years of increases have totaled only 6.4% or about 1 1/2% per year. The cumulative short fall to St. Joseph's Hospital over the six year period is in excess of $2.2 Million, with $1.2 Million of that shortfall coming in just the last two years. Specifically the impact of the reduced market basket increases over these last few years has produced a doubling of our DRG discount amounts, those discounts increasing from $2 Million during fiscal year 1986, to $4 Million in discounts in fiscal year 1988. The Medicare program's recent decision to attack outpatient service payments has impacted our DRG discounts as well. The changes in outpatient reimbursement which are just now beginning to be put in place more emphatically, have taken its reimbursement toll in the last several years. Our Medicare outpatient discounts increased from $390,000 in fiscal year 1986, to $650,000 in fiscal year 1988. Adding both our inpatient and outpatient DRG discounts for that three year fiscal year period results in a total Medicare discounted dollar amount of $10,700,000.

As you know, the Medicare age population tends to be a significant utilizer of hospital services. At St. Joseph's, during our last fiscal year, Medicare beneficiaries accounted for 40%, or approximately 2,000 of our inpatient admissions, and accounted for 45% of the hospital's revenue.

A question that is certainly to be raised as this information is presented is to what extent has the hospital addressed the issue of cost containment. The hospital, its Board of Directors, and management have certainly been concerned in this area and I would indicate to you that two years ago our overall expense increases were roughly 7%, our last fiscal year that increase was reduced to 6%, and based on the pace of our expenses for the current fiscal year we would predict an overall expense increase of less than 4%. St. Joseph's Hospital evaluated our overall staffing patterns and are currently operating with 60 less employees than we did when the PPS system started. At the same time we have felt it necessary to add a number of services to address the needs of people in our service area.

We were pleased, Senator, that you had the opportunity today to visit one of those newly added services, namely our Community Hospice. We feel it has been a very valuable addition to our services to the community and as you found out has extended that service far beyond the city limits of Minot. We have added a vital outpatient partial care day treatment service for mentally ill patients, which we feel is a valuable adjunct to our inpatient treatment program. We have greatly expanded our day surgery program that admits and discharges surgical patients on the same day. Currently 50% of our surgical cases are handled through our day surgery program. That figure was approximately 25% just five years ago. A vast majority of these cases had previously been two or three day hospital stays. 36% of the cases handled in our day surgery program are Medicare patients.

A Home Health Agency was developed at the hospital to assist moving patients from an inpatient status to their home environment in as expeditious manner as possible, while ensuring the patient, while in their home environment, receives the appropriate quality nursing services they require. The hospital has also greatly expanded its outpatient services for the chemically dependent patient, an effort to treat those patients who may not need the more intensive, more expensive, inpatient services. The hospital has developed an information/advice/education program for senior citizens in our service area. This program provides personal assistance in understanding the complexities of their insurance programs and offers frequent screening and testing programs as well as educational sessions on topics of particular interest to seniors, dealing with their health and well-being. We have worked in concert with the local chapter of the Mental Health Association, and the North Central Human Service Center. This cooperative effort resulted in the joint development of the Psycho Social Center, a social club for the mentally ill, which is operating as an adjunct of the hospital's mental health program.

With the support of the many friends of the hospital, within the last two years the hospital developed a Foundation with a dedicated board of directors. This Foundation is assisting us to raise funds for essential and new services we feel are needed in our community. We certainly feel, however, this should not negate the government's obligation to reimburse us fairly for services rendered.

Specific reference to these additional programs and services was made in the context of the recognition of the changes that are taking place in health care delivery today, and specifically St. Joseph's efforts to address those changes. Also to indicate to you that there have been concerted efforts on the part of our hospital to look at cost containment methods, reductions in staff and other changes that we have made, only to see our overall financial position eroded by continuing Medicare cuts made in promised market basket payments.

As you know, the actual DRG payment amount is only one of several factors involved in the reimbursement to hospitals. The Medicare program initially recognized its responsibility in assisting hospitals by paying their fair share of depreciation expenses incurred by the hospitals. The budget paring that has taken place in the Medicare program has already cut 15% in Medicare's fair share of the hospital's depreciation expense. That represents a $100,000 decrease in payments the hospital should receive. The proposed fiscal year 1990 budget would propose increasing that shortfall by another 10%, reducing

Medicare's equitable share of that expense by a total of $170,000 per year.

I had mentioned previously the shift that is being made toward outpatient services. This year the Medicare program has put in place reduced reimbursement for ambulatory surgery care which for St. Joseph's Hospital will result in a $350,000 decrease in payments for that service. The cut back on the amount allowed for outpatient radiology services will impact us in the amount of a $190,000 decrease in payments. Both of these reduction totals are predicated on similar volumes of service to Medicare patients during this coming year.

St. Joseph's Hospital recognizes that the Medicare program has made a commitment to the senior citizens of this country, and we at St. Joseph's have made every effort to be responsive to both the needs and the expectations of the medicare eligible people whom we serve. Certainly Congress and the administrators of the Medicare program are aware that this population group is the fastest growing segment of our population. We feel that for us to adequately provide the needed services, that, minimally, the full market basket increases originally promised to the hospitals should certainly be forthcoming for a segment of our population which is receiving nearly 50% of our resources.

We at St. Joseph's were extremely fortunate to receive the rural referral center designation at the start of the prospective payment system. Had we not received that designation, we would be receiving annually $500,000 less than we currently receive. Because we fell just short of the population requirements that would have designated Minot as an urban Hospital similar to Grand Forks, Bismarck and Fargo, we receive some $500,000 less per year, or approximately $300 per Medicare discharge less than hospitals located in those three North Dakota communities. However, I mention this example only to relate to you just one of the distinctions that exists in the system, and would suggest that the efforts on the part of the Medicare program in Washington to realign categories and designations of hospitals only compounds the problem. We do not believe it is fair to take what is now a six year period of underfunding and begin shuffling those dollars from one group of designated hospitals and passing it along to another group in an effort to provide [illegible] fixes for a total hospital service. I feel there needs to be an extensive, total reevaluation of the DRG system, and in the meantime would strongly encourage that continuing "band aid" fixes be curtailed and that Congress acknowledge their original commitment to the hospitals of the country to fund market basket price increases.

Thank you for this opportunity to present St. Joseph's concerns to you this evening.

Senator CONRAD. Next, we are going to hear from Dr. David Rinn, the University of North Dakota Family Practice Center at Minot. Dr. Rinn, again, we welcome you. Also want you to know that you're free to summarize your testimony, and your full written statement will appear in the record. Dr. Rinn.

STATEMENT OF DR. DAVID RINN, UNIVERSITY OF NORTH DAKOTA FAMILY PRACTICE CENTER, MINOT, ND

Dr. RINN. Thank you, Senator Conrad. I am Dr. Rinn. I have been a practicing physician in North Dakota for approximately 25 years. First 17 years were in a small community, Cando. The last 8 years I have been here in Minot as the program director for Family Practice Residency Training Program. I am also now an assistant dean for Northwest Campus of the University of North Dakota School of Medicine.

I welcome this opportunity to testify before the Senate Budget Committee, and I would like to thank Senator Conrad for bringing this hearing to North Dakota to give the citizens in his home State a chance to participate.

Senator Conrad, there is indeed a crisis in rural health care today, from the problems of maintaining a high standard of care with shrinking finances to hospital closings to physician shortages and malpractice problems. yes, indeed, there is a crisis in rural health care.

I would like to discuss several of these major areas today and show their relationship with these problems to medicare and how medicare has contributed to these problems.

First of all, the standard of care. The standard of care is probably one of the most important issues of medicine today. For years, patients from all over the world have come to the United States to receive care, and this suddenly is no longer occuring. The standard of care in the United States has gradually decreased. One of the major reasons for this decrease in the standard of care is the DRG. If you notice the sign up here, the differential based on a DRG payment. DRG stands for Diagnostic Related Groups.

The DRG has significantly contributed to this decrease in standard of care. This system actually promotes less care from both hospitals and physicians with financial incentives for both. It is no wonder that the standard of care is starting to hurt. Any payment system that actually tends to reduce the standard of care should be reconsidered, and I would ask this committee to do that.

Secondly, in the shortages. A recent survey indicated that 60 percent of all the hospitals in the United States are currently recruiting primary care physicians. That is primarily internal medicine and family physicians. This fact illustrates the medical doctor shortage problem. There is not only a primary care shortage, but there is a maldistribution of physicians presently in practice, with the rural areas having the greatest shortage. In the past, third-party carriers, including medicare, have paid exceptionally high fees for certain subspecialties, thereby encouraging new physicians to seek training in these subspecialty areas. This has, in part, resulted in a shortage of primary care physicians.

It is my understanding that Congress is currently studying a revised physician reimbursement schedule. I would hope this committee would consider the following recommendations.

One, the general fees paid to primary care physicians should be enhanced, and hopefully would be to the degree that new physicians would not look elsewhere for their specialty training, and thereby address this critical physician shortage area.

As noted above, the greatest degree of problem in physician shortage exists in the rural areas. It would be my suggestion that the committee consider a higher fee schedule for primary care physicians practicing in rural areas.

It is also my understanding that some have proposed a regional difference in this proposed fee schedule. I feel that this would promote regional physician shortage problems, and I would strongly oppose that concept. Over the past 10 years, hospitals in rural America have struggled to remain open and viable. By your own figures, it is anticipated in the near future a number of hospitals in rural America will be unable to stay open. One reason for this problem is the difference in payments to rural and urban hospitals. I am really not certain why it takes more money to take care of a particular problem in a urban hospital than a rural hospital. It would seem that almost the opposite would be true. Rural hospitals spread their costs over a smaller number of patients, and it is simply logical that maintaining the same equipment to save the patients would cost more per patient, not less.

The closing of rural hospitals is a major concern. But for routine care, in this modern day of travel, that's not the greatest concern. The biggest concern is the loss of emergent care. This committee would—should do whatever is possible to maintain rural hospitals, but I would also ask the committee to address the emergent care needs of rural communities when hospitals do in fact close.

Next problem is malpractice problems. The rising number of costs of malpractice suits throughout the United States has created a tremendous rise in malpractice insurance premiums. These have generally reflected increases in overall medical costs, and in some cases the cost of malpractice insurance has become cost prohibitive, resulting in a service being discontinued. In a rural setting, when the number of physicians is small and one physician discontinues a service, that may mean that that service in that community is discontinued. Many rural areas have already lost several services due to this problem, although tort reform bills are currently being considered which would assist in solving this problem. I would again emphasize the need to enhance the fee structures for primary care rural physicians.

I would like to address one last issue, and that is regarding teaching hospital problems. Since I am a rural family practice residency program director, I would like to discuss this problem I am personally involved with, and that is Federal funding for teaching hospitals through medicare.

Presently, teaching hospitals are reimbursed by percentages of medicare patients, both through a direct and indirect mode. The direct mode provides for hospitals to recoup their direct expenses for residency training programs, and this includes such things as resident and faculty stipends, insurance, and program rents. The indirect payment, a formula is involved which pays teaching hospitals an added amount for each medicare admission. This is to reimburse the teaching hospitals since, historically, teaching hositals have sicker patients that are more complex, and that residents in training order more test.

Over the past few years both the direct and indirect components have been reduced by the Federal government. It is my understanding that further reductions are being considered. If indeed the Federal government is trying to address the physician problems and rural hospital problems in primary care, it would seem illogical to cut these funds. These funds are assisting in educating physicians in this area.

I would ask your committee to re-examine this issue. It would seem more logical to increase rather than decrease this funding.

Thank you, Senator Conrad, for this opportunity.

Senator CONRAD. Thank you, Dr. Rinn, and if you'd just stay there for 1 minute. I would like to ask you if you are seeing the national trends play out locally. The national trend being that with medicare reimbursements to rural physicians being lower than in urban areas, has that made it more difficult to attract young physicians to rural areas? Are you seeing that trend develop locally in this area, and beyond that, at UND?

Dr. RINN. I think certainly that is a component in North Dakota. We have other problems. One of those is illustrated by the weather outside today. But I think that the physician reimbursement schedules certainly do contribute to problems in rural areas in general, yes, sir.

Senator CONRAD. The greenhouse effect is going to take care of this temporary cold spell. We're told that we're the Caribbean of the future. In fact, we're starting to sell lakeshore lots on Lake Sakakawea. So I think that problem is going to take care of itself, apparently.

Let me, on a more serious note, ask you if you could give us any specifics on what's happened with malpractice rates, in your experience. Could you give us some illustration of what's happened to malpractice rates?

Dr. RINN. Well, I can indicate that when I first started back in the 1960s practicing medicine in North Dakota, it cost me approximately $350 to $500 a year for malpractice insurance, which was almost a much better policy than is offered today, in many respects. Today, that same policy is costing somewhere between $25 and $30 thousand, depending upon what practice the physician actually is doing. I would suggest that in some areas, such as obstetrics, the premiums are even higher.

Senator CONRAD. Could you give us some illustration, for example, in obstetrics? Would you have, off the top of your head, what those numbers might be in this area?

Dr. RINN. I cannot really reflect a good number for you. My premiums are paid by the University of North Dakota, and Dr. James may be able to enlighten us on that. But I have heard that if you're an obstetrician—and this is hearsay, mind you—that your malpractice may be $150 thousand a year. And this is what I meant by the cost prohibitive nature of some of these problems. If it costs you more than you can recoup, then you decide not to deliver babies. And in a small town, if you're the only one delivering babies, then that community loses that service.

Senator CONRAD. Thank you, very much, Dr Rinn. We do appreciate your participation in this hearing.

Next, we will hear from Terry Hoff, the president of Trinity Medical Center in Minot. Welcome, Terry, and you can feel free to proceed with your testimony.

Let me just indicate for the purposes of keeping the other people who are here informed of how I intend to proceed. With the next two witnesses, Gordon Smith, the administrator of Ellendale Hospital, and Brian Dockter, the administrator of the Community Memorial Hospital in Hettinger, I'll ask them to come up and be a panel, and I will give a chance for us to open it up to the audience for questions in addition to the questions I might have. And the same will be true for the next panel, which would be Ed Smith, a consumer witness from Minot here, and Glenn Fornes, also a consumer witness from here in Minot. I had asked them to be part of a panel and we'd open it up to the audience for questions and comments as well. Because to the extent possible, I want to make sure we get as full a participation as possible at this hearing, and we want to hear what people who are here can share with us in terms of their experiences. So with that, Terry, if you would proceed.

STATEMENT OF TERRY HOFF, PRESIDENT, TRINITY MEDICAL CENTER, MINOT, ND

Mr. HOFF. Thank you, Senator Conrad. Before I begin, I have written comments for the record from the Nebraska Hospital Association, the South Dakota Hospital Association, the North Dakota Hospital Association, and the American Hospital Association, which I'll leave for you.

Senator CONRAD. Maybe I can just indicate, too, this is the only hearing of the Senate Budget Committee outside of Washington, DC, on this subject this year. So this is a unique opportunity, obviously, for the State of North Dakota to be heard on this subject, and that's why there is interest from other States in having their testimony entered into the record at this hearing.

Mr. HOFF. Thank you, again, Senator. I certainly appreciate the opportunity you have provided for us to address the crisis facing hospitals in rural North Dakota. Indeed, we have reached critical levels in the financial viability of hospitals in our State.

When we look specifically at our institutions, we see a reflection of what the hospitals look like in our area. Financial pressures are commonly shared by all of us in rural health care. If I may go to the charts,[1] Trinity Medical Center, as part of its commitment to rural health care, besides the operation of Trinity Hospital, also assists in the management of two rural facilities in northwest North Dakota. And I have three charts which I think reflect three different examples of what happens in health care. All three charts are essentially similar. The green line represents charges that we bill patients for services rendered. The black line represents the expenses in each institution. And then the bottom graph on each chart represents the net operating margin or loss. And each institution that we'll talk about have some significant different problems.

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[1] Not available for reproduction.

In this particular case, as you can see, the gross charges, the charges we bill for revenues—I guess I need to emphasize that charges billed for services does not mean what we collect. Certainly, that's the issue today as medicare discounts. But in this particular institution, the charges stayed relatively level and took a drop. And again, this reflects part of what Dr. Rinn is saying. It was a community that had three physicians. One of the physicians left town, and the revenues dropped drastically. As you can see, the hospital reacted, and their expenses did drop, but they can't drop nearly as drastically as the revenue. In a small rural hospital, you're talking about one nurse on the ward. You can't do less than one. Those kinds of things. But even in this particular instance, in the year 1987, where charges did exceed expenses, in that same year they were showing an operating loss. And their operating loss has been consistent and, of course, dropped drastically in 1988.

Senator CONRAD. Would it be safe to conclude this hospital's survival is threatened?

Mr. HOFF. It is. And right now, the way it is surviving is essentially by a community fund drive.

The next example again relates to one of the area community hospitals. And again in this particular instance, the revenues have been approximately what the expenses are. Again, this is amount billed, not amount collected. And when we assisted in the management, we instituted a cost savings program and did reduce expenses in 1988. But again, the gross charges, amount billed to patients, does exceed expenses, but as you can see, in 1988, they still showed a net operating loss.

This particular chart [1] represents Trinity. And from 1986 to 1987, our gross charges have been growing on a consistent basis, and I would point out that our expenses have been growing at a lesser rate than our charges. But this represents what's happening to our bottom line, our operating margin. The funds we use to replace facilities and equipment has dropped drastically in 1987, and in 1988 in fact showed a slight loss.

So I think the three different examples represent three different situations.

The reasons for those changes are numerous. But I think a couple of things that we would like to talk about is among those reasons are an increased number of elderly being served in western North Dakota, and they require more intensive service and more days of hospitalization. In simple terms, it's an increase in the volume of services provided.

Another problem that we're facing is the diminishing supply, as well as the increased demand, for health care professionals. This has compounded the expense pressures that we face. Salaries for nurses, as an example, have been increasing at a far greater percentage than medicare reimbursement rates. As an example, at Trinity Hospital we anticipate nursing salaries will increase approximately 8.4 percent in this coming year. Transferring that to cost per patient day means an increase of approximately $6.65 per patient day. Medicare's increase for 1989 is approximately 3.9 percent, or translating that is $3.06 per patient day. So just on nursing salaries alone, the medicare shortfall is $2.59 per patient day, or representing approximately $144,000. And that problem compounds itself when you take and consider all the other inflationary pressures of other health professionals, like physical therapists, respiratory therapists, pharmacists, et cetera. And it doesn't even include things like increase in utility costs, groceries, and all the other things that we provide.

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[1] Not available for reproduction.

That's the conclusion of my comments, and I certainly would entertain any questions.

Senator CONRAD. Thank you, Terry. I would like to ask you, what do you think the contributing factors are to the nursing shortage that we're experiencing?

Mr. HOFF. There are several factors. I think that one of the issues is that opportunities for young women today are so varied. Nursing is traditionally a female profession, and certainly young women can go into nearly any profession today that even 10 years ago wasn't open to them, accounting, engineering, you name it, and it's common for young females to be training in that. I think that's one of the major reasons.

Truly, nurses—it takes a special person to be a nurse. Our nurses are very dedicated, caring people, and they have to be, because they have to put up with miserable hours, PMs and nights, weekends, that a lot of other professionals don't have to put up with. So I think some of those working condition types of things are——

Senator CONRAD. If we could just get people to be sick during the day, would that help?

Mr. HOFF. We could save a lot of money if we could just be open from 8 to 5.

Senator CONRAD. Are we working on that?

Mr. HOFF. I'm afraid not.

Senator CONRAD. Let me ask, Terry, one other question. And that is what effect has the new emphasis on outpatient surgery had on your institution?

Mr. HOFF. That's an interesting question, and I think all of us in health care are doing a great deal more in outpatient surgery. When you look at what's happening at Trinity Medical Center, your volumes change a great deal.

Two things happen, though. You don't get that direct decrease in cost, primarily because you dump a whole bunch of staff into one day. All the ancillary testing—you have to get histories and physicals on the charts, you have to do the labs, x-rays, all in that same day, where before you could take two days to do it, so you have some peak loads you have to staff for.

I think the other issue is it does decrease overall revenue for hospitals. In our institution, we always say it takes four outpatients to equal an inpatient. So outpatient volumes, although they have been increasing greatly, have not been increasing as rapidly as the declines in inpatient utilization.

Senator CONRAD. What levels of occupancy are you experiencing at the facility?

Mr. **Hoff**. Right now on our staff beds, it's approximately 66 percent.

Senator **Conrad**. And that, no doubt, is being affected by outpatient surgery.

Mr. **Hoff**. Yes.

Senator **Conrad**. Is that having a dramatic effect?

Mr. **Hoff**. I think, you know, under the Medicare Program. there's a couple of things. The preadmission authorization has had a major effect, A.M. admissions, you can't come in the night before. And then, of course, finally, yes, the outpatient surgery and all the things we do on a one-day basis now.

Senator **Conrad**. Would a severity of illness variance or factor make a difference with the DRG system, from your perspective?

Mr. **Hoff**. Yes; it would. I think it would be helpful. I guess, overall, we're concerned about the total funding from the medicare system.

Senator **Conrad**. All right. Thank you very much. I appreciate your testimony.

Mr. **Hoff**. Thank you.

[The prepared statement of Mr. Hoff follows:]

SENATE BUDGET HEARING

February 16, 1989

I appreciate the opportunity you have provided to address the crises facing hospitals in rural North Dakota. Indeed we have reached critical levels in the financial viability of hospital sin our state. When we look specifically at our institutions, we see a reflection of what the hospitals in North Dakota look like in general. Financial pressures are commonly shared by all of us involved in rural healthcare.

Reasons for this crises are numerous. Among those reasons are the increased number of elderly who require more intensity of service and more days of hospitalization. In simple terms an increase in the volume of care provided.

The diminishing supply as well as the increased demand for healthcare professionals have compounded the pressure of meeting salary demands for these professionals. Salaries for nurses have been increasing at a greater percentage than medicare reimbursement rates. For example: Trinity Hospital - we anticipate salary increases for our nursing staff of approximately 8.4% this year. Translating that increase to patient costs means an increase of $6.65 per patient day. Medicare increases for 89 are estimated at 3.9% or an increase of $3.06 allowed. That means on nurse salaries alone we will have a shortfall of $2.59 per patient day or $144,000.

The problem compounds itself when spread over time and all other classificatins of healthcare professionals. (PT, Phar, RT, Lab tech, Rad tech etc.)

Senator CONRAD. Next, we will hear from Gordon Smith, the administrator of the Ellendale Hospital, and Brian Dockter, the administrator of the Community Memorial Hospital in Hettinger. And if both of those witnesses could come up. Are they both here? Come up and join us. We'll hear first from Gordon Smith, the administrator of the Ellendale Hospital, and then Brian Dockter, the administrator of the Community Memorial Hospital in Hettinger. It's my intention that we start with Gordon and then go to Brian, and then if you'd both stay up at the dais, we have a chance to involve the audience and have them ask questions, make comments. We'll just open it up and see—give people a chance to express themselves.

So first, Gordon Smith. Welcome.

STATEMENT OF GORDON U. SMITH, ADMINISTRATOR, DICKEY COUNTY MEMORIAL HOSPITAL

Mr. SMITH. Thank you, Senator. It's a pleasure to be here. I already noted that we are speaking in the same terms. You used the word "awesome." That is in my testimony. You used the word "brink." That is definitely in my testimony. And I noticed that you borrowed the red ink for the graph from my facility. Sometimes it helps to have a little sense of humor. It prevents the tears.

As the senator mentioned, I am Gordon Smith, the administrator at Dickey County Memorial Hospital in Ellendale, and I'm going to deviate a little bit from the written testimony and go through a couple of things, and then I'll summarize it.

But since I was raised in Park River, North Dakota, I'm well aware of the North Dakota rural lifestyle and the host of benefits it provides to us. In fact, as a 10-year-old, I spent three weeks in that hospital with rheumatic fever. Today, I have a daughter who has asthma. So even though my family enjoys small towns, I don't know that we could live in one if we didn't have accessible health care in that community.

And since I have spent my past 12 years as an administrator of three small hospitals, I'm bringing both my professional and personal concerns to you.

As the theme of this meeting states, it is now well recognized that small hospitals are in severe financial distress. Or in other words, medically speaking, the condition is critical, the prognosis is bleak.

Now, undoubtedly some of you here would like to probably tell me that costs of health care are out of control, and maybe will before the night is out. And I surely won't deny that those costs are high. But if you would please remember, I am a consumer as well.

Likewise, though, I could tell you that no one is regulating the prices that our hospital pays for liability insurance, medications, utilities, food, and on and on. We have liability insurance companies that tell us how to operate, regardless of additional expenses involved. If we don't conform, they will cancel our policy. Simple as that. And they know they can exert this pressure because we have virtually no other companies to turn to. We buy supplies based on the quality and the prices of those supplies. When we decide to purchase an item, we feel confident we have the best price possible. But sometimes we're locked into prices. I personally once attempted to negotiate a better price on a copying machine, only to be told by the salesman that he couldn't lower the price because their company had a government contract; giving me a better price would mean that the company would be legally required to pass on the same savings to all previous and future government purchases of that machine. So we do the best we can with what has become even less, due to the Medicare Program's inability to recognize some of these factors.

I would like to relay one piece of information which further speaks to this inability of the Medicare Program. During these past 5 years, we initiated a fund development program, which Mr. Hoff already alluded to. It's not the same one, but you see them more frequently now. With this donated money, we have purchased all 30 lifeline units that we utilize and, just lately, a piece of physical therapy equipment. Without the donations, we would have needed to borrow the funds and to pay interest on those loans.

During this past January, we experienced a medicare audit. They annually do this. And at that time, I was informed that the development expenses, roughly $300, were not allowed by Medicare. Now, this is not a different Medicare Program. This is the same Medicare Program that we're talking about that pays your hospital bills. It's also the same one that has cut our reimbursement, necessitating the fund drives. The rationale given for the disallowance was that these expenses aren't patient care related. Now, how can this program make that statement regarding a piece of physical therapy equipment? Yet if we borrowed the money, the interest expense on the loans would have been probably five times the $300. So we spent $300, saved the Medicare Program $1,200, but the $300 is not a justifiable expense.

So you can easily see how the administration of the Medicare Program can adopt only the rules—not only rules and regulations to circumvent the legislation that's already in place, but they even have a difficult time rationalizing savings or realizing them when they see them.

I would now like to highlight just a few select portions of the written testimony. And, incidentally, copies of that are available on the back table, and I would urge you all—I guess, I probably don't have enough to go around—to pick one of those up. It's 15 pages long. If you think it's too long, please read the last page. And then, hopefully, you'll get a little knot in your stomach, as I did when I wrote it, and maybe a little motivation to learn some more as well.

So let's go back and talk about medicare and medicare reimbursement. Wally Strauch already mentioned some of the statistics from here in Minot. Wally, I can double those. But we serve—currently 82 percent of our patient days are medicare recipients. And don't misunderstand me. We are well satisfied, pleased to be able to serve the elderly. Seventy percent of our admissions are medicare recipients.

So if you do have that written testimony in front of you, I call your attention to page 5 of that. That page and the narrative of it explain the impact of the current medicare reimbursement on our hospital, right on up so medicare discounts to the Medicare Program have grown between 1983 and 1988 by 407 percent. 407 percent. That's not a typo. Those are the actual figures. That's for every hospital—or medicare patient hospitalized. The medicare outpatient discounts, over the same period, have grown by 391 percent. Again, no typo, 391. So it's little wonder then that this hospital has lost $175,000 over the past 50 months. That converts to about $42,000 a year. Yet on that same page, if you look at the total expenses for the hospital, you'll find that they have declined by 2 percent. The expenses per medicare patient day have declined by 7 percent.

Now, the reward—and I use that term "reward" loosely—is that we in turn see the medicare discounts per patient day increased by 387 percent. As a result, the general public has also been rewarded, since they in turn—you and I who aren't medicare recipients but who have health insurance or are self-paid—since those of us must then pay the full rates needed to offset those medicare discounts.

Also along with the copies of that testimony are copies of a weekly medicare inpatient and outpatient payment sheet. These are labeled Exhibits A and B and are separate from the stapled together portion. The handwritten figures on those sheets represent the contractual allowance, the discount, the write-off, or whatever you want to call it, noncash, for each claim. The "Paid Amount" column represents cash payments from medicare. The column entitled "Other Amounts" is the amount due and deductible and/or coinsurance from the patient or their supplemental insurance carrier. Those are then the total cash received by the hospital.

On the reverse side of each, you will find totals for each category, including the handwritten amount of the medicare discount. And on the one sheet that you have that says—I believe it's Exhibit A—that's the inpatient portion of it, and there is approximately $51,000 written off on that one weekly payment sheet. There were numerous claims on it, so it's not quite a normal weekly payment sheet. There's a little more on there than normal. But the write-off itself is $51,000. In 1983—going back to that page 5—you would find that for the entire year, 55,000 was written off to Medicare.

So today I'm requesting this committee to return small hospitals to the previous cost base system for hospitalized patients. In addition, I am asking for a similar approach to outpatient reimbursement. And details of both of these proposals, as well as the rationales, are again found in those copies that have been provided.

In summary, I believe it is our Nation's obligation to recognize the growth in the number of medicare recipients, just as we as a Nation recognize the growth in the indigents and the homeless. As a Nation, and based on those five problems that I have identified in the written testimony, we have not quite turned our backs on rural America, but we are definitely standing sideways. But I would emphasize turning our backs on small hospitals not only turns our backs to the rural elderly, it turns our backs to the rest of the rural population served by these hospitals, too. Without adequate reimbursement, access to rural health care will be nonexistent.

Finally, I would like to make just one final point. That is that I would encourage any of you to visit your local community hospital, and if you ever get down to Ellendale, stop in and visit with us. You're more than welcome. The only stipulation that I have in terms of that visit is that you would also be willing to stay as long as it takes for you to understand medicare reimbursement, too.

Thank you for the opportunity, Senator.

Senator CONRAD. Thank you, Gordon.

[The prepared statement of Mr. Smith follows:]

SENATE BUDGET COMMITTEE HEARING

MINOT, NORTH DAKOTA

FEBRUARY 16, 1988

"CRISIS IN RURAL HEALTH CARE"

Testimony Presented by:

Gordon U. Smith

Administrator

Dickey County Memorial Hospital

Ellendale, North Dakota

Description

Dickey County Memorial Hospital is a 21-bed acute care facility. It provides a wide range of services typically found among hospitals in the 20 to 50 bed range. It also provides Swing-Bed services and operates a Home Health Agency. Prior to implementation of the Prospective Payment System (PPS), it received sole community provider designation from the Health Care Financing Administration (HCFA) and retains that designation today.

Additionally, the hospital provides radiographic and laboratory services to the local medical clinic. The community of Ellendale and the surrounding area should then benefit from the nonduplication of such equipment and services. However, the hospital must then staff these departments with a schedule which coincides with the clinic's schedule and financially bear the brunt of reimbursements limits.

In terms of volume of services, the hospital has always served a high proportion of Medicare recipients. In 1983, 55% of the inpatient admissions and 65% of the inpatient days were Medicare patients. In 1988, these same two percentages had grown to 70% and 82% respectively. Therefore, the hospital is highly dependent upon Medicare reimbursement for its financial well being. It is pleased to be able to provide these services for the Medicare recipient as well as the entire population it services. However, the reason I am here today is to explain why the continuation of those services, for the Ellendale community and area, is in jeopardy.

Overview

To begin, it must be recognized, contrary to many misleading publications, that the Medicare Program has never paid hospitals billed charges. It did not from 1965 to 1983 and it does not, with a few exceptions, do so today. From 1965 to 1983, hospitals were reimbursed according to Medicare's definition of "reasonable" costs. Since 1983, inpatient hospital charges have been paid via the Prospective Payment System while outpatient services are paid on the cost based system or via a fee schedule.

Therefore, we also need to define what in the industry is known as contractual allowances. Basically, these are the dollars not paid by anyone and must be absorbed or written-off by the hospital. In mathematical terms, this is the difference between Medicare payments, patient deductibles and/or co-insurance and the hospital's billed charges for the service.

There is only one deviation from this. Even though it is by far the exception, and not the rule, later discussion will address it too so it needs to be mentioned. The exception is that the Prospective Payment System, since it is a fixed payment by diagnosis, does allow a hospital to retain a payment which exceeds the billed charges. However, this too has become a problem.

Additionally, the rationale for establishing each hospital's PPS rate needs to be briefly explained. Hospitals were assigned a "base" year. Each hospital's individual base year costs become part of its own specific PPS rate. The remainder of the rate was based on regional and national data. Therefore, the hospital's individual PPS rates are a blend of its own costs plus other hospitals costs.

Problem Definition

Rather than state flatly that the Medicare payments are inadequate (which would be a true statement), we need to examine several different aspects of the system. Only then will we understand the implications and impacts on the small, rural hospital. The problem can then be broken into the following segments:

1. Inpatient reimbursement and the question of the PPS being truly applicable to small hospitals.
2. Effects of PPS reimbursement.
3. Outpatient reimbursement with the application of laboratory and radiology fixed fee schedules.
4. Sole community provider status.
5. Actions taken by HCFA via Professional Review Oranization (PROs).

Problem Discussion

1. Inpatient reimbursement and PPS applicability to small hospitals.

Introduction of the PPS legislation was embraced by the majority of the hospital industry. I was among the supports. It was touted as a system which would reward efficiency. But what really was lacking was a true study of this method of reimbursement. At the time of the adaption, New Jersey utilized such a system and this system then became the basis of the Medicare reimbursement system.

The problem with this system from a small, rural hospital perspective is well illustrated by comparing New Jersey to North Dakota. New Jersey can be classified as predominantly an urban state, North Dakota is predominantly rural. American Hospital Association data on bed size, highlights this point. Only one of New Jersey's 96 total acute care, nongovernmental hospitals has less than 50 beds. North Dakota has 38 of 50 hospitals in this group. So we have a system, which was applicable to larger urban facilities being applied to small, rural hospitals. Unfortunately, the legislation was implemented without testing the New Jersey system to a small, rural model.

But we only need to look within the philosophy and the application of that philosophy to find another serious flaw. The application of PPS reimbursement, with the exception of capital expenses, is that a direct relationship exists between hospital volume and all other hospital expenses. In practice, this is only partially true. Hospitals can control certain supply and staffing expenses as volume fluctuates. Other expenses cannot be controlled in direct proportion to volume. A few examples would be insurance costs, utility costs, and basic staffing costs. To illustrate this, let us assume you are the plant engineer. Last month the hospital averaged 20 patients per day. This month, the average is 10 patients per day (50% less). How do you reduce the electric and fuel oil consumption by 50%? Or perhaps you might want to examine this on a more personal level. Your income was $20,000 per year, but you lost that job and are now earning $10,000 per year. How would you reduce your home heating and electric bills by 50%? You cannot accomplish this! Yet, a hospital, under the PPS philosophy, is expected to adjust all expenses in direct proportion to volume and income.

Compounded the problem was the rationale of utilizing only one fiscal year to reflect each hospital's individual costs and PPS rates. As I already have illustrated, hospital volume can vary from day to day, month to month, and year to year. This is true of all hospitals. Yet a small hospital can experience greater fluctuations on a percentage basis.

For example, Dickey County Memorial Hospital's patient day volume between 1982 and 1983 increased by 15.6%. The following year it declined by 28%. Therefore, 1983, the hospital's base year for determining PPS rates was a high volume year. The result was less costs per patient due to the higher volume. Obviously the hospital's PPS rates would have been higher if 1982 or 1984 data had been utilized instead. Considering two or more years data would have produced a more realistic PPS rate.

2. Experience of PPS Reimbursement.

As already mentioned, the hospital today treats more Medicare recipients than it did in 1983. This is illustrated on Table 1 which was prepared with data from the Medicare cost reports for 1983 and 1988 as well as hospital audit reports. What this table illustrates is a comparison between the previous medicare cost based payment system and PPS.

The definition of contractual allowances or Medicare write-offs was given earlier. Since contractual allowances are based on hospital rates as well as Medicare payments, we need to examine the charges first. This is because a charge increase, without a Medicare payment increase, would directly flow, dollar for dollar to contractual allowances. Thus some contractual allowance amounts would be solely due to charge adjustments. Likewise, raw data will not produce a true comparison due to differences in volume. Hence, the data is converted to Medicare patient days of service and discharges (number of Medicare patients served).

Patient day charges to Medicare patients increased by 33% while charges per discharge increased by 39%. Over this same time period, the contractual allowances or Medicare write-offs increased by 38% per patient day and 407% per discharge! Obviously, this points out a definite problem.

I would now call your attention to the total hospital expenses in those years as found on the bottom of Table 1. Likewise, I should point out that the hospital did change it's fiscal year ending date so the data reflects charges over 50 months not five full years. What we see is an increase of expenses of 3.1% in total. That would be 0.6% per month or 0.74% per year.

TABLE 1
PPS CONTRACTUAL ALLOWANCES
AS COMPARED TO PRE-PPS ALLOWANCES

	2-31-1983	2-29-88	% Increase
Medicare Patient Days	1937	2049	5.7
Medicare Discharges	298	302	1.3
Average Length of Stay	6.50	6.78	4.3
Inpatient Charges	$684,158	$964,060	40.9
Charges/Patient Day	353.20	470.50	33.2
Charges/Discharge	2295.83	3192.25	39.0
Inpatient Contractual Allowances	$55,598	$285,608	473.0
Allowances/Patient Day	28.70	139.39	387.4
Allowances/Discharge	186.57	945.72	406.8
Outpatient Charges*	$47,386	$80,385	69 6
Outpatient Contractual Allowances	7,434	36,507	39.10
Allowance/Charge	15.6%	45.4%	
Total Hospital Expenses	$1,065,429	1,098,594	3.1

Source: Medicare Cost Reports of 1983 and 1988

*Unable to calculate by volume of patient seen since volume is not recorded on Cost Report.

Now, and with all due respect to the members of this Committee, I ask you WHERE IS THE REWARD FOR EFFICIENCY? A SCANT INCREASE IN EXPENSES, WHICH IS WELL BELOW INFLATION LEVELS AND THE HOSPITAL MARKET BASKET FOR THESE YEARS, IS REWARDED BY A 407% INCREASE IN CONTRACTUAL ALLOWANCES! Or stated differently, and going back to the promise of reward for efficiency, "WHERE'S THE BEEF"? This is MY "beef"!

3. Outpatient Reimbursement/application of laboratory and radiology fee schedule.

I would again call to your attention Table 1 and the outpatient data. Frankly, this data is more difficult to compare due to the lack of outpatient volume on the Medicare cost report. Therefore, we can see that Medicare charges increased and surmise that this volume would have increased. Again we see the overall increase in contractual allowances, i.e. 39.%. Likewise, the percentage of contractual allowance to the charge shows a very significant increase, i.e. from 15% to 45%. Basically, what this means is that for each $1.00 charged in 1983, 15c was written-off. Today, 45c of every dollar charged is written-off.

Why is this? As I mentioned earlier, the hospital owns and operates the only local laboratory service and performs all the medical clinic procedures. But because of this, the hospital laboratory is deemed by Medicare to be a "reference" laboratory. As a reward, we have been reimbursed according to the 1984 Deficit Reduction Act at 62% of the prevailing fee schedule rates. Therefore, due to the "Deficit" act, our laboratory, (again from Medicare cost report data) is operating at a "DEFICIT" of its own. These losses were $5780 in 1987 and $9600 in 1988.

As you already know, this same "logic" is now going to apply to outpatient radiographic services in 1989. Again, I would remind you that the hospital performs all the radiology services for the medical clinic. Therefore, what I will tell you next year, is that the radiology services have gone from a 15% to a 45% level of write-off and that it TOO operates at a "DEFICIT".

4. Sole Community Provider Status:

To adequately discuss this issue we again need to revisit the post. Prior to the introduction of PPS, the Health Care Financing Administration (HCFA) recognized the unique role of these hospitals. In doing such, it waived cost limitation regulations applicable to other hospitals. This recognition continued with the advent of the PPS. Specifically, PPS legislation allowed the sole community provider hospitals to maintain the 75% hospital specific level of blending the PPS rates. It also contained language allowing for adjustments if a sole community provider experienced inpatient volume declines in excess of 5%. While this designation remains, one must seriously question the outcomes, (or lack thereof).

Previously, I mentioned the implications of utilizing only one fiscal year to determine hospital specific costs. As we have moved through the subsequent years of PPS, we have seen many hospitals discontinue their sole community provider status. Why? Simply, because their designation did not keep pace with the reimbursement rates they could realize by going to the 50%-50% and 25%-75% blends. Obviously, there is something amiss when this happens. I can only surmise, but I would think that these hospitals had experienced the opposite of our situation. Their base years of establishing their rates, had higher costs per patient due to low voluem.

A second point merits very serious, frank discussion. That point is that then original legislation contains the recognition of the sole community provider, but the administration of the Medicare program has chosen to ignore it. This choice seems to have been made in regard to the administration of the 5% adjustment plus an overall negative policy toward the sole community providers.

This hospital experienced a 5% decline in inpatient volume and requested the adjustment. However, the single word "extraordinary" was inserted into the regulations describing the circumstances. Therefore, all the burden of proof was placed on the hospital and left HCFA with its own means and authority to determine approval. Or in other words, the intent was to grant very few adjustments. That is exactly what happened. Only a few adjustments have been granted. This facility was fortunate enough to receive the adjustment, but only after intervention by legislators over a period of two years.

To emphasize this point, I would like to quote Dr. William Roper, the HCFA administrator. From one newsletter the hospital receives, "Medicare alone cannot and should not be seen as the financial guarantor of rural hospitals." From a recent ABC television news report regarding a rural Montana hospital, "the real question is: should the Medicare program which itself is in financial difficulty, be the primary vehicle for subsidizing these small, isolated rural areas, I don't think so." Dear Committee member, I am not here today asking for guarantees or subsidization. I am here asking for what is already in the law, that is decent payment by the Medicare program on hospital bills.

Let us then look forther at this term "subsidization' and the "financial difficulty" of the Medicare program. I would contend that Table 1, and those earlier discussions of increased contractual allowances of 407%, amounts to this hospital's direct subsidization of the Medicare program. This is the exact opposite of Dr. Roper's statement. Next, I would call Table 2 to your attention. Basically, what this table illustrates is that UPDATES TO THE MEDICARE BASE RATES FROM 1985 THROUGH 1988 HAVE BEEN BORNE SOLELY BY THE PUBLIC THROUGH HIGHER DEDUCTIBLES! In fact, you can see that Medicare payments would actually be LESS! Now, who is subsidizing whom? The answer is that the rural public and the sole community provider have subsidized the Medicare program.

Before leaving this point, I would like to make one final statement. Let us loose our senses and say that this is, in fact subsidization. Let us as well agree that the base rate difference between this hospital and an urban hospital is 15.5% (one of the lower estimates I have seen.) Therefore, 15.5% of the hospital's 1988 base rate (see Table 2) of $2288 is an additional $355 per admission. The Medicare program would then pay an additional $71,283 to an urban hospital for the care of those patients ($355 X 206 admissions). Let us assume that a $50,000 subsidy would keep this hospital open. It would then seem to me that the Medicare program is benfitting by $21,283 by this subsidy instead of closing it and paying the more to an urban hospital! Makes sense to me! Does it to you?

TABLE 2
MEDICARE; WHO IS PAYING FOR IT AT DICKEY COUNTY MEMORIAL HOSPITAL

FACTS:
(1) On 01-01-85 the base rate for a DRG with weight of 1.000 was $2,197.00.
(2) Patient deductible for 1985 was $400.00 per benefit period.
(3) The base rate on 01-01-88 for the DRG with a weight of 1.000 was $2,288.00.
(4) The patient deductible effective 01-01-88 is $540.00 per benefit period.
(5) For the calendar year ending 12-31-87, 86 (or 29.4% of 292) Dickey County Memorial Hospital patients were re-admitted in the same benefit period.

SIMPLE COMPARISON: For one patient with a DRG weight of 1.000 and assuming one admission per Medicare benefit period.

		Patient Pays		Medicare Payment
1985 Admission:				
DRG Value = $2,197.00	-	$400	=	$1797
1988 Admission:				
DRG Value = $2,288.00	-	$540	=	$1748

NOTE: The medicare program pays LESS in 1988 than in 1985.

COMPLEX COMPARISON: For 292 medicare admission with 86 of those patients readmitted in the same benefit period (medicare then pays 100% of the DRG amount with patient not paying the deductible for the second admission). All admission with a weight of 1.000 and assuming the hospital again exercises the same number of Medicare admissions.

1985 Medicare Payments:
206 Admission X 1797 (2197-400) = $370,182
86 Readmissions X 2197 = 188 942
TOTAL MEDICARE PAYMENTS $559,124

1988 Medicare Payments:
206 Admissions X 1748 (2288-540) = $360,088
86 Readmissions X 2288 = 196,768
TOTAL MEDICARE PAYMENTS $556,856

NOTE: There is no increase (actually 0.4% less) in total dollar payments made by the medicare program in 1988. But the medicare recipients did pay approximately $10,000 more in deductibles due to the increase from $400 to $540. Stated differently, the "so-called" increases to the DRG amounts (which are always reflected as a total dollar amount) have been borne by the public (patient) and not the medicare program.

5. Actions taken by HCFA via Professional Review Organization (PROs).

Again, we must briefly revisit the inception of the PPS system to understand this problem. Professional Review organizations are hired by HCFA to monitor hospital utilization. Their primary objective is to save Medicare funds. They do this by retroactive review for medical necessity of inpatient admissions and length of the patient's stay. It is contended that a hospital can "game" the PPS by admitting patients who do not need inpatient care. Likewise, a hospital could "game" the PPS bykeeping the patient hospitalized too long and additional payments could be received. Let us start by returning to the underlined word "hospital". Hospitals, hospital administrators or hospital utilization review staff do NOT admit or discharge patients. Physicians do this and they do so based on their medical judgement at the applicable time.

The PRO then reviews these Medicare patients' records. We have come to expect them to change the patient's primary diagnosis to one which will pay the hospital less. Every now and then they even change one which results in additional payment. And we really do not object very strongly to the need of some of this review. After all, HCFA will fire them if they do not make these changes.

BUT WE DO OBJECT WHEN HCFA INSTRUCTS THESE ORGANIZATIONS TO DENY HOSPITAL PAYMENTS WHICH VIRTUALLY WOULD PLACE AN 87 YEAR OLD PATIENT IN THEIR HOME WITHIN 12 HOURS OF SURGERY. We do not feel it is appropriate to expect a wife, who is in frail health herself, to care for a spouse who has just undergone surgery.

AND WE DO OBJECT WHEN RULES ARE ADOPTED WHICH ELIMINATE PPS PAYMENT ON SHORT STAY ADMISSIONS. As mentioned before, the PPS rate system is founded on base year averages. This means that the rates of low cost and high cost cases were included to establish an average cost. Please refer to Table 3 for a simple example. The PPS says there will be some cases of financial gain (few) and some cases of financial loss (contractual allowances or write-offs). The rules now set forth by HCFA have established for us a new service called "outpatient observation". This would be acceptable, except we have never

TABLE 3

GAMING ILLUSTRATION

BASE YEAR/DRG 123: METHOD OF DETERMINING PPS REIMBURSEMENT

PATIENT	LENGTH OF STAY	COST
#1	7 Days	$4,000
#2	5 Days	3,000
#3	3 Days	2,000
#4	1 Day	1,000
Totals	16	$10,000

Average Length of Stay = 4.0 days
Average cost/case = $2,500

CURRENT YEAR/DRG 123: APPLICATION/IMPACT OF GAMING

PATIENT	LENGTH OF STAY	COST	MEDICARE PAYMENT
#1	7 Days	$4,000	$2,500
#2	5 Days	3,000	2,500
#3	3 Days	2,000	2,500
#4	1 Day	1,000	2,500 * see below

*But the "game" is to reimburse this 1 day stay as an outpatient observation service which would be approximately 80% of the $1,000 charge or $800 instead of $2,500. The few cases where Medicare payments exceed charges is then even less.

Sources: Medicare Manual HIM-10, Section 210 plus PRO denial letters of impatient payment for 6-88 and 8-88 admissions.

provided such a service and never provided it in the Medicare base year. If we had, our base years costs and today's reimbursement would be higher, i.e. low cost cases would have been excluded. So application to this leaves us with even fewer cases of financial gains. The main point to this proglem is that HCFA has changed the rules on one end of the spectrum without adjusting the other side of the equation. Being a rural state, let me give you a rural example. You are a farmer and I am a grain buyer. The two of us agree that I will buy your grain based on the average price at five different but specific markets on a given day. Based on this mutual understanding (called PPS) you give me the grain. A day later I pay you for the grain, but you notice my payment does not agree with the average. I, in turn, tell you I unilaterally decided to eliminate the highest of the five prices listed and average the remaining four prices. Do you agree with this? Of course not, and neither should the Medicare program believe that they can expect hospitals to accept this.

Problem Summary

Health care is itself a complex science and we find that problems of reimbursement are as complex as the care we provide. Therefore, we are faced with multiple issues in our attempts to resolve the problem. It is my belief that others could present testimony on other factors of the Medicare payment system which are in need of change. I have tried to emphasize those points which are most important to the small, rural hospital. Likewise, I have demonstrated the efficiency shown by this one small, rural hospital.

I would be negligent if I did not mention the hospital's staff of employees. That staff dug in during the low volume time mentioned. They went over two years without a pay raise even though they greatly deserved one. They accepted less work hours (we do not staff empty beds as some members of Congress would like you to believe). They recommitted themselves to saving even more expenses. They always remembered their first priority of quality patient care. Surely, if they had embraced the true philosophy of PPS, i.e. dollar for dollar cuts, they could have done more but only at the expense of quality. We could save more if we processed infectious patients' linen with other linen. We could re-use needles and syringes. We could refuse to provide the most up-to-date antibiotics since others are cheaper. We could sell the new radiographic equipment and replace it with an older model which would mean more radiation exposure to patients. BUT THIS IS NOT OUR MISSION. We will provide quality care even if it means going out of business!

Alternative Actions/Solutions

1. Sole Community Provider Hospitals should be allowed to immediately return to the cost based reimbursement system until a more equitable system can be designed and tested. Those hospitals which have voluntarily determinated this status should be allowed to request re-instatement (and without submitting another application or other means of justification). Other small, rural hospitals of less than 50 beds, even though they did not originally have this designation, should be allowed to apply for sole community provider status, but with relaxed criteria.

Rationale: Time is of the essence for many small, rural hospitals. Enactment of legislation to correct these problems at a future date is going to be too late. Data for cost based reimbursement is already in place since Medicare cost reports have continued to be filed. Changes to application of current legislation via modified rules and regulations by HCFA is not a viable solution. Recent history of HCFA actions has resulted in little trust and faith in their organization with the only remedy being local action through the courts. Court action consumes valuable time and financial resources.

2. Return Sole Community Provider Hospitals to cost based reimbursement immediately and on a permanent basis. Other comments in number 1, addressing eligibility would be applicable.

Rationale: Is the same as in number 1.

3. Communities which are served by only one radiographic and laboratory service, either within the hospital or medical clinic setting, should be allowed sole provider status for such. Reimbursement to these facilities should be set at a cost based level.

Rationale: Arrangements such as these represent sound financial planning. The days of national health planning (P.L. 93-641) they would have been loudly applauded, not financially penalized for such planning.

4. Recalculate the base costs of PPS, for small, rural hospitals using three years data.

Rationale: The data is already available to HCFA and this should be able to be implemented without much time delay.

5. Continue the present PPS method, but expand capital pass through methods to include other "fixed" costs such as utilities, insurance, etc. For sole community providers, this would also include the fixed salary costs of staffing levels.

Rationale: Hospitals have very little control, as already mentioned in the problem discussion of these expenses. Again, the "fixed" costs are already available on the Medicare cost reports. Determination of care staffing levels would be time consuming and, in all fairness, should be accomplished by an independent body. Care staffing costs are very real to the small hospital. Even nursing service staffing levels cannot vary in the same proportion as volume. The small hospital's volume could drop to a very low amount, but Medicare conditions of participation still require the staff to be present.

Recommended Action/Solution

It is my personal opinion that alternatives number 1 and 2 should be enacted. While the first alternative does return to cost based reimbursement, it is only for the time allowed to develop a better model and a system which can be fully tested prior to implementation. Before hostily vetoing this idea, Congress should consider that we are really talking about the hospitals in the nation which are the only source of hospital care in that community. This is called access to health care. Therefore, this alternative retains, and does not torpedo access. Furthermore, we are usually talking about less costly hospitals.

Alternative number two mirrors the same logic. Again, we are talking about access. Plus, we are talking about sound financial planning, much of which did not come about with P.L. 93-641. I may draw some criticism from the medical clinic side on this, but perhaps the financial rewards can accomplish what P.L. 93-641 did not. Surely, the sole entity providing these services should not be financially penalized for consolidations of this type!

Conclusion

Now that we have covered the past and present, let us look forward to the future under the present system. Let us say it is 1991 or 1992. The doors to this hospital were locked yesterday. It has gone the way of the rural hospitals, closed because it could no longer pay its creditors (due to the heavy reliance on Medicare reimbursement). I physically turned the key on the front door. I did so only in a physical sense knowing that it had been efficiently operated. The real or actual parties turning the key were in Washington and Baltimore. The physicians have already left the community because they needed a hospital for their patients. Yet, I wonder about the elderly neighbor. The ambulance is parked at the front of his home. Will he be alive when the ambulance reaches Aberdeen or Jamestown? Of course, Medicare will pay for his ambulance services even though it is more expense to Medicare to have him transported the distance to those larger communities. And, if he is alive when they get there, he will receive good care, but it will again cost Medicare more since he is in a larger hospital. But that is now the way it is to be for all rural residents, young and old. Once health care was accessible to us. Today, we live with less and only memories of the past and the benefits that were once ours. As the ambulance pulls away from the neighbor's house, I think back to 1989. Maybe I should send a copy of my testimony to those on the current Senate Budget Committee. Perhaps it would help some other small, rural hospitals who are on the brink.

Thank you for the opportunity to present this testimony. Those of us in rural America eagerly await the necessary actions to resolve these problems and to the continuation of accessible health care for rural America. Personally, I look forward to working with you in any way to mantain that accessibility.

Respectfully,

Gordon Smith
Administrator

Senator CONRAD. I want to draw your attention to the testimony that Gordon has provided in writing. It's 15 pages. It is exceptionally well done. And I would just like to, for a moment, read to you from the conclusion.

> Now that we have covered the past and present, let's look forward to the future under the present system. Let's say it's 1991 or 1992. The doors to this hospital were locked yesterday. It's gone the way of the rural hospitals, closed because it could no longer pay its creditors. The physicians have already left the community because they needed a hospital for their patients. Yet I wonder about the elderly neighbor. The ambulance is parked at the front of his home. Will he be alive when the ambulance reaches Aberdeen or Jamestown?

And I'm skipping part of this. But let me just continue.

> Once health care was accessible to us. Today we live with less and only memories of the past and the benefits that were once ours. As the ambulance pulls away from the neighbor's house, I think back to 1989. Maybe I should send a copy of my testimony to those on the current Senate Budget Committee. Perhaps it would help some other small rural hospitals who are on the brink.

As I say, I have not read it all, but it is powerful and compelling testimony that you have provided to this committee, Gordon, and I'm indebted to you for it.

Next, we will hear from Brian Dockter, administrator of the Community Memorial Hospital in Hettinger. Then, as I indicated, we will open it up to the audience.

STATEMENT OF BRIAN J. DOCKTER, CHIEF EXECUTIVE OFFICER, COMMUNITY MEMORIAL HOSPITAL, HETTINGER, ND

Mr. DOCKETER. Thank you, Senator Conrad. Distinguished guests and colleagues. My name is Brian Dockter. I appreciate your invitation to discuss the issues of medicare and the crisis in rural hospitals from my perspective as chief executive officer of a small, rural hospital in Hettinger, North Dakota. I present this evening on behalf of myself and that of Dr. Gerald T. Sailer, medical director of United Clinics, P.C., also of Hettinger, North Dakota.

Community Memorial Hospital is a 46-bed hospital located in a southwestern North Dakota community of 1750 people. We have 13 physicians on our medical staff practicing out of United Clinics, P.C., which is adjacent to the hospital. Of these 13 physicians, two are radiologists, two are internal medicine specialists, one is a pediatrician, one is a general surgeon, and the remaining seven are family practitioners. All are board certified in their respective specialties. Our primary and secondary service area encompasses over 18,000 square miles and includes approximately 35,000 people. We are a JCAH accredited organization and have on-site, full-time CT scanning, nuclear medicine, ultrasound, echocardiography, dedicated mammography, computerized pulmonary function lab, physical therapy, respiratory therapy, and technologically advanced laboratory services. Our health care services has been nationally recognized as a leader in innovative rural health care delivery.

Frequently, we hear people describe rural health care as behind the times, poorly managed, and even unnecessary. We believe that the 35,000 residents in our service area receive the finest in health care services, and, further, we believe that the vast majority of other rural facilities deliver excellent health care as well.

In preparation for this discussion this evening, I reviewed the testimony provided to Senator Burdick by my predecessor, Jim Hubbard, on August 17, 1987. I am particularly struck by how in principle little has changed and how applicable his testimony is to today's discussion, some 18 months later. He focused on the urban-rural differential for hospital reimbursement and inadequate physician reimbursement and ambulatory care.

Projections are that some 700 rural hospitals and health care facilities will close over the next 5 years. While I am pleased to say that Community Memorial Hospital in Hettinger, North Dakota will not be one of those, that does not lessen our plight nor that of the remaining 3500-plus rural facilities. We are dealing with a system of reimbursement surrounded by false promises and decreasing, inadequate funding.

In late 1983 and 1984 when the Prospective Payment System by DRG was being negotiated, HCFA entered the arena, promising a budget-neutral system that would maintain adequate funding, based on market basket calculations for labor, inflation, and other costs. What we have seen since that time is an abandonment of their word and a steady trend in monetary cutbacks. We saw a system that at its inception rewarded facilities that padded their base year expenses and penalized those facilities that were holding the line and/or were less astute on how to go about the padding process.

During that time, I was employed by a 400-plus bed regional referral center in an urban community as DRG coordinator. I witnessed multiple years of monetary windfall from the DRG payments. In a budget-neutral system, it is clear then that someone also lost vast amounts of Medicare funding. Most of the industry literature indicates that rural facilities are the ones who took it on the jaw.

I am not here to testify in support of a Robin Hood mentality, where we rob from the urban rich and give to the rural poor. We must clearly recognize, though, that an urban-rural differential for medicare funding that is as wide as 31 percent for the very same care is, at best, discriminatory against the rural populace. What I am in support of is restoration and a commitment to a system of adequate funding for all segments of the industry.

Let me emphasize in this that the bad guys in this play are not the urban facilities but rather the Federal bureaucrats who design and implement regulations, yet know so little about the system.

So we go on. We hear lip service attesting to the discrimination of this system. We read about legislation introduced into Congress that will begin to address this rural crisis sometime in the early 1990s. This is a matter of urgency, and the early 1990s is not soon enough.

There is little difference in the expenses to operate a rural facility versus an urban facility per patient day that is, by most part, not artificially deflated by reimbursement. We order our food supplies and our medical supplies from the same companies as our urban counterparts. With the exception of water and sewer, we obtain our utilities from the same companies as does our urban counterparts. With the exception of land, our physical plants, including architects, engineers, and building materials, come from the very same companies as our urban counterparts.

With the exception of our skilled and clerical personnel, which come from the local job market, we compete in the very same regional market for doctors, nurses, therapists, and technologists, which are in critical short supply, to staff our facility, as do our urban counterparts. And it's so interesting, none, no, not one of these individuals has ever said to us, "Because you're a rural facility, we'll charge you less," or "I'll take less salary." In fact, to the contrary. Because we have less volume and are so remote, we get charged more. On one hand, HCFA and medicare say to us, "Because you're a rural facility, we'll pay you less, take it or leave it."

Regarding the matter of physician reimbursement. The rural primary care physician's bread and butter are office calls and nonsurgical procedures, yet reimbursement is much greater for specialty care. Rural communities cannot compete salarywise with the large multispecialty clinics where primary care is subsidized by specialty services, and we have seen this effect demonstrated in our physician recruitment efforts over and over. I believe that this situation requires study and the devise of a plan that would allow rural physicians to be compensated on a par level with their urban counterparts or offer tax incentives to locate in underserved areas.

Community Memorial Hospital is an organizational member of the National Rural Health Association, which has filed suit against the Federal government regarding discrimination against rural facilities, demonstrated through the urban-rural price differential. Recently the American Hospital Association has also taken a stand on the inappropriateness of the urban-rural differential.

Tonight, Senator Conrad, we are asking your support in keeping access to health care in the forefront for your constituents, our patients. Thank you for your attention.

Senator CONRAD. Thank you very much, Brian. I appreciate your testimony as well.

[The prepared statement of Mr. Dockter follows:]

SENATOR CONRAD AND DISTINGUISHED GUESTS:

I appreciate your invitation to discuss the issue of Medicare and the crisis in rural hospitals from my perspective as Chief Executive Officer of a small, rural hospital in Hettinger, North Dakota. I present this evening on behalf of myself and that of Dr. Gerald Sailer, Medical Director of United Clinics, P.C., also of Hettinger, North Dakota.

Community Memorial Hospital is a 46-bed hospital located in the southwestern North Dakota community of Hettinger. We have 13 physicians on our Medical Staff practicing out of United Clinics, P.C., which is adjacent to the Hospital. Of these 13 doctors, 2 are radiologists, 2 are internal medicine specialists, 1 is a pediatrician, 1 is a general surgeon and the other 7 are family practitioners. All are Board Certified in their specialties. Our primary and secondary service area encompasses over 18,000 square miles and includes approximately 35,000 people. We have on-site, full-time CT scanning, nuclear medicine, ultrasound, echocardiography, dedicated mammography, computerized pulmonary function lab, physical therapy, respiratory therapy, and technologically advanced laboratory services. Our health care system has been nationally recognized as a leader in innovative rural health care delivery. Frequently, we hear people describe rural health care as "behind-the-times," poorly managed, and even unnecessary. We believe that the 35,000 residents in our service area receive the finest in health care, and we believe that there are many other rural facilities that deliver excellent health care as well.

In preparation for this discussion I reviewed the testimony provided to Senator Burdick by my predecessor, Jim Hubbard, on August 17, 1987. I am struck by how little, in principle, has changed and how applicable his testimony is to today's discussion, some 18 months later. He focused on the urban-rural differential for hospital reimbursement and inadequate physician (ambulatory) reimbursement.

Projections are that some 700 rural hospitals and healthcare facilities will close over the next five years. I am pleased to say that Community Memorial Hospital in Hettinger, North Dakota, will not be one of those. However, that does not lessen our plight, nor that of the remaining 3,500+ rural facilities. We are dealing with a system of reimbursement surrounded by false promises and decreasing inadequate funding.

In late 1983 and 1984 when the Prospective Payment System by DRG was being negotiated HCFA entered the arena promising a budget neutral system that would maintain adequate funding based on market basket calculations for labor, inflation, etc. What we have seen since that time is an abandonment of their word and a steady trend in monetary cutbacks.

We saw a system that at its inception rewarded facilities that padded their base year expenses and penalized facilities that were holding the line and/or were less astute on how to go about that.

During that time I was employed by a 400+ bed regional referral center in an urban community as DRG Coordinator. I witnessed several years of monetary windfall from the DRG payments. In a budget-neutral system, it is clear then that someone also lost vast amounts of Medicare funding. Most of the industry literature indicates that rural facilities are the ones who took it on the jaw then.

I am not here to testify in support of a Robin Hood mentality, where we rob from the urban rich and give to the rural poor. However, we must clearly recognize that an urban/rural differential for Medicare funding that is as wide as 30% for the very same care is at best discriminatory against the rural populous.

And let me emphasize in this, that the "bad guys in this play" are not the urban facilities but rather the federal bureaucrats who design and implement the regulations, yet know so little about the system.

And so we limp on . . . we hear of lip service attesting to the discrimination of this system . . . we read about legislation introduced into Congress that will begin to address this "rural crisis" sometime in the early 1990's. This is a matter for urgency . . . AND THE EARLY 1990'S IS NOT SOON ENOUGH, MR. SENATOR!!!

There is little difference in the expenses to operate a rural facility versus an urban facility per patient day that is by the most part not artificially deflated by reimbursement. We order our food supplies and our medical supplies from the same companies as our urban counterparts. With the exception of water and sewer, we obtain our utilities from the same companies as does our urban counterpart. With the exception of land, our physical plant--including architects, engineers, building materials--come from the same companies as our urban counterparts. With the exception of our skilled and clerical personnel which come from the local job market, we compete in the same regional market for the doctors, nurses, therapists and technologists, which are in critical short supply, to staff our facilities as does our urban counterparts. And it's so interesting, none--not one--of these individuals has ever said to us, "Well, because you're a rural facility, we'll charge you less" or "I'll take less salary."

In fact, to the contrary, because we have less volume or are so remote, we get charged more . . . "On the other hand, HCFA and Medicare say to us, because you're a rural facility, we'll pay you less . . . take it or leave it."

Regarding the matter of physician reimbursement. The rural primary care physician's "bread and butter" are office calls and non-surgical procedures. Yet reimbursement is much greater for specialty care. Rural communities cannot compete salary-wise with the large multi-specialty clinics where primary care is subsidized by specialty services. I believe that this situation requires study and the devise of a plan that would allow rural physicians to be compensated on a par level with their urban counterparts.

Community Memorial Hospital is an organizational member of the National Rural Health Association which has filed suit against the Federal government regarding discrimination against rural facilities demonstrated through the urban/rural price differential. Recently, the American Hospital Association has also taken a stand on the inappropriateness of the urban/rural differential. Tonight, Senator Conrad, we are asking your support in keeping access to health care in the forefront for your constituents--our patients. Thank you!

Bryon J. Dockter, Chief Executive Officer

Senator CONRAD. Let's do this. Let's open it for people in the audience for comments or questions that you might have. And while we're giving people a chance to think if they have a question or a comment they would like to make, let me ask you this, Brian. I understand that your hospital is eligible for sole community hospital status, yet you have made a determination not to apply for that. If that is correct, what are the advantages and disadvantages of sole community hospital status?

Mr. DOCKTER. Sole community hospital status was a benefit that was allowed to rural facilities on the basis that their previous costs might have been greater than what advancement into the DRG system would have. However, we were one of the organizations that was not astute enough to pad our bases or costs, and so our costs, prior to going into DRGs, was considerably lower than what the national rate is. And so from our perspective, there was no incentive for us to become a sole community provider.

Senator CONARD. All right.

People in the audience, anybody with a question or a comment? Yes, sir. If you would go to the microphone and identify yourself for the record, and if you have a name that's difficult to spell, if you would spell it for our transcriber.

Mr. KYES. My name is Jim Kyes (K-y-e-s). I have a simple question. I don't know what you mean by discount from the medicare—or for the medicare system. Would you explain that, please?

Senator CONARD. Gordon or Brian, either one.

Mr. SMITH. It's a topic that's near and dear to my heart. A discount is basically the amount that is written off the books. It's not billed to anyone. We cannot legally collect it from anybody. If we would attempt to collect it, that constitutes fraud. The discount then, in terms of calculating it, is the difference between the hospital's total charges on, let's say, your bill and the medicare payment and then possibly you probably had a deductible in there.

So let's just take an example. Let's say that your bill was $5,000. I can deal with even numbers. Medicare would pay $2,000. Your deductibie, let's say, is $500. So that's $2,500 that the hospital collects: $2,000 from medicare, $500 from you. The difference of that is another $2,500. That is totally written off. You never see it. We don't collect it. Like I say, we can't.

Now, the outcome of that, in terms of the other population, is that obviously there is a shortfall there. So that shorfall is passed on to the other consumer who either by themselves or their insurance company then pays the full charge.

Did I explain that fully?

Senator CONARD. I thought that was an excellent explanation. Let me ask, and again we'll go back to the audience after this question. It strikes me, as I look at the statistics, Gordon, that you presented in your testimony, a disproportionate percentage of your patients are medicare patients, disproportionate to national averages. I assume that in large part is because our population—our State population is older than the population nationally. If you have a breakdown of what other States' population base looks like, ours is substantially older. In fact, in a way, we are a good indicator of what's to come nationally, because our total population nationally is aging. Now, because of the way medicare reimbursement works and because of the age of our population and because you have got a disproportionate number of medicare patients, I assume that just adds to the pressure that's put on a hospital like yours. Is that analysis correct?

Mr. SMITH. Yes. I'd say catagorically you hit the nail on the head. The bad news is that due to that high proportion of medicare patients, there are relatively fewer other patients to absorb the difference.

Senator CONARD. And so if this—one thing that we might take as a message to our colleagues, who are in other parts of the country who may not be feeling the brunt of this as we are, but who have more rural hospitals, that is, don't qualify for the urban designation, as their population ages, they best be mindful of where this is all headed. Because today the bell tolls for us; very soon the bell may be tolling for them.

Other questions or comments from the audience? Yes, sir. If you would go to the microphone and identify yourself for the record.

Mr. THOM. My name is Bob Thom. I'm a citizen of the United States. I was a citizen of Canada. And I might be amiss in bringing up the subject of the whole medical system.

Senator CONARD. That's fine.

Mr. THOM. Is that fine?

Senator CONRAD. Sure.

Mr. THOM. Because we are talking about older patients here tonight.

But I think our system is in a shambles. I would like to see a task force, and maybe there has been, visit the Canadian system of medical treatment. And I raised a family there for 40 years, and everybody paid into it through a tax structure. I'm not positive how. But I know in Manitoba, it cost me $8 a month. In Saskatchewan, it was zero. The people I've talked to lately say that the medical care in Canada is not as good as in the United States. I have many friends who live in Winnipeg, in a little rural town where I came from, and still has a hospital there, that receive excellent medical care. I feel that the small hospitals will be in worse trouble not because of the older population, but because my staff just got a notice from Blue Cross and Blue Shield that their insurance cost will be $340 a month for the top policy.

I think we need a real look, Senator. And it started in Saskatchewan 45 years ago. I don't know if you have heard of Tommy Douglas—through what was called CCF at that time, now is the New Democratic Party—but he flew over to England, lined up several plane loads of physicians, came back to Saskatchewan and said, "Boys, this is the way she's gonna be." And they did lose physicians into Manitoba, Alberta, and B.C., and the United States. Forty-five years ago. And since then, there have been several governments take their position in Saskatchewan, and nary a one has ever dared take off the socialized medicine system. It's also in England, and I understand in the Scandinavian countries. So I think we should be looking at the whole medical field, not only medicare.

But I have people working for me. We're very fortunate. Seventy-five percent of our Blue Cross and Blue Shield is paid for by our company, but they count that as a benefit. But I know of lots of employees in this town that are not going to get sick because they can't get sick and they won't go to the hospital because they can't afford it, and if they do go to the hospital, your hospitals are going to pay for it because they haven't got the money to do it.

So I think we need a very serious look at the whole situation, right from the ground up. Thank you very much.

Senator CONRAD. Thank you, sir.

Yes, ma'am. If you'd identify yourself.

Ms. ALBERTSON. Yes. I'm Blanche Albertson, and I am also a former Canadian. When Trudeau set up the system in Canada, he gave each province 6 months to set up a system or he would set it up for them. So each province had a choice of what type of system they set up. And in Alberta, we had Blue Cross, and Alberta Health Care for the doctor.

And before we got that, the doctors set up their own insurance system, and it was called MSI, which meant Medical Insurance, Incorporated. And there was no difference between that and what they put in the government put it in, except that everybody was covered. It was national health care. And each province had a choice of what type of system they set up.

And when I lived in Canada, we paid every 3 months, just like you do for medicare here. But we didn't pay portion of what you pay here, because they didn't have the bills you have here. I have been here 12 years. And I got a statement from the Alberta Health Care for what they paid out to the doctors every 6 months. And when we went to the hospital, we paid $5 at the desk, and we never got a bill.

My father was in the nursing home and died in 1987.

He was in there for 2 years. And the nursing homes up there are sponsored—or are subsidized by oil royalities. His social—you don't have social security up there; it's old age pension. He paid his old age pension into the home every month, and that was all that was ever paid. When he died, he still had $60,000 for his—in the bank, which is—and also, he happened to have died the 7th of May, and the rest of his pension check went back into the estate. And I don't know why we can't do something similar here.

And see, there's a fallacy here where people think that the whole system across Canada is the same. It's not. Each province set up their own. That's why I think when they go up there to investigate, they should not just go to one province, they should to to all 12 provinces and find out what they're doing.

Senator CONRAD. All right. Yes, sir.

Mr. DIDIER. Senator Conrad, my name is Mike Didier. I'm administrator at Turtle Lake Hospital in Turtile Lake, North Dakota.

I would like to concur with my colleagues in all of their testimony. Some of these issues get—get very upsetting to us. And I'd like to give you some specific examples of somewhat what we're talking about here.

First of all, let's talk about health care costs. OK. I have a director of nursing. My director of nursing has 15 years seniority in our facility. She has 21 years in the field. She is salaried at a wage equivalent to the janitor in another local industry. OK? Forty percent of my staff is at minimum wage or slightly above. If they adjust minimum wages they're talking about, those 40 percent would be under that minimum wage.

I get upset. I'm sorry.

Senator CONRAD. No; that's fine.

Mr. DIDIER. Fifty-three percent of the total cost of this health care is payroll. OK? And I have a hard time understanding with those kind of figures how we can scream about costs of health care.

I followed your meetings throughout North Dakota, and I saw Mr. Pomeroy speaking about the climbing insurance rates. That's what the public is screaming about. OK. What we do in health care is we increase our charge as medicare deficits fall. As those deductions from revenue fall, that shifts the cost from medicare to third-party payers, Blue Cross, Aetna. The people here have a right to scream about insurance premiums, but the cause is not abuse in the hospitals, it is not astronomical costs of health care, but is deficit funding from the Federal government.

I listened, and I have followed many of the statements made on national policy. I heard our leaders say there has to be a vested interest between government, the private sector and the communities, business and the communities.

Our facility 3 years ago lost our physicians. One retired after 35 years, and another physician moved to New Jersey, where he could better support his practice. The result of the loss of those two physicians was $320,000 in 1 year. The businesses in our local community donated over $210,000 in bonds and donations. At the same time, medicare, the government, gave us a 3.1 percent increase for that year, and by their own figures sae a 6.65 percent increase in the costs. That is not a share in—in the interest of health care, and the Federal government is not carrying their proportion of that.

I had an opportunity to be in Phoenix, Arizona, in January of this year, and I heard a couple people from Canada comment on the health care system. We had a number of administrators from the various provinces of Canada, and I want to tell you a couple of comments they said to me. They said in many, many ways health care in the United States has much to offer over what we have in Canada, but they said, "Let me tell you what the basic difference is. In Canada, the people of Canada accept health care as a right, and we fund and we treat it as such." In this country, Senator, I do not believe that we acknowledge health care as a right.

One other situation that I think demonstrates this. We have an individual that came to our hospital. He was admitted with pneumonia. He's a medicare patient. Multiple system problems, coronary disease, kidney disease, pulmonary disease, which is typical in many of these elderly patients. After 4 days stay in the hospital, he had a massive stroke. The reimbursement on that individual was paid for that admitting diagnosis of pneumonia, and the hospital on a single patient took a shortfall of $12,000. If I were to give my numbers in my hospital, the number of discharges, the number of patient days, to a statistician, what he would tell you is it is impossible, on averages which the DRGs are based on, to overcome that single patient.

DRGs for small hospitals are not even statistically relevant, and unless we change these things, we are not going to have our rural hospitals. Thank you.

Senator CONRAD. Thank you very much. I appreciate that testimony.

Let me just counterargue with you for a minute on one point you made. Let me first indicate I agree very much with your underlying assertion. Obviously, the shortfall in medicare reimbursement compared to the increase in costs is a part of this problem. But I also think we have got to face the fact that health care costs are exploding on us and that it is a major part of this problem.

In our hearing on—in our hearing in Fargo, we entered into the record what's happened with total health care costs in this country since 1965. In 1965, total U.S. spending on medical care, 1965, was $42 billion. 1987, 22 years, it's up to $500 billion. It had gone from 6.9 percent of gross national product to 11.1 percent of gross national product. If present trends continue, we will double by 1995 from where we are now in costs, double by 1995, triple by the year 2000. And in the year 2000, in this country, we will be paying $5500 per year for every man, woman, and child in this country for medical care. We will be absorbing 15 percent of our gross national product for medical care, which will be approximately twice what any other industrialized country in the world will be paying for medicare.

Something's wrong. Something is wrong. And at the very time those costs are escalating like that, we have this enormous growth in terms of people who have no coverage.

And I would be the first to acknowledge what you say, sir, is correct, especially from the vantage point of the rural hospitals that we serve and that you are administrator of, and the two gentlemen here. But I think we also have to acknowledge that a major driver here, and for the Federal government as well—I'm on the Budget Committee, and I have watched the pressure on medicare. It is stunning, the increase. The only one other thing growing faster in the Federal budget than medicare, and the only thing that's growing faster, is interest on the debt. Now, that says something about our current situation.

Yes, sir.

Mr. Didier. Just a comment to that, Senator. I was at the State Health Department for a meeting the other day, and one of the individuals of the State Health Department put some data, that I'm sure is available to you, on the screen. I am pulling this off the top of my head, so all of the numbers won't be accurate. If we close the 16 most unprofitable hospitals in North Dakota, rural facilities, OK, and that goes all the way up to those hospitals with less than 50 percent occupancy, we will save about 8.6 percent of the cost of health care in North Dakota. And that statement isn't exactly true, because those individuals that did not have access to those 16 hospitals would go to those urban hospitals——

Senator Conrad. And cost more.

Mr. Didier [continuing]. And it would cost more. So we would lose by closing those 16 hospitals. And I guess a challenge is then where is the cost of health care coming from. And I can guarantee you it is not rural hospitals.

Senator Conrad. I agree completely. I agree completely. I think it's fair to say and accurate to say health care costs are skyrocketing. It is also fair and accurate to say that rural hospitsls are not the ones to be pointing the finger at and saying, "That's the problem." I think you're exactly right in that. Let me——

Mr. DOCKTER. Senator Conrad, if I may respond to both Mr. Thom's and Mrs. Albertson's comments.

Senator CONRAD. Absolutely.

Mr. DOCKTER. I would, though, encourage us, when we talk about the health care delivery system of Canada and great Britain, that we must also recognize that that is not a foolproof system either, and that other issues surface in those systems, such as issues of health care rationing and the fact that patients wait up to 18 months to 2 years to receive surgical treatment that patients in the States receive in 3 to 4 months. While you sit and shake your head, Mrs. Albertson, I, too, have studied that, and that is in fact accurate.

Mrs. ALBERTSON. I lived there.

Mr. DOCKTER. And one other comment. I would have to ask then why are so many Canadian physicians trying to bust the doors down and come down to the United States and practice?

Mrs. ALBERTSON. I lived in Edmonton for 50 years, and after the health care came into effect, I don't know one established physician that left there, in Edmonton, Alberta. The ones that came out of medical school. And, of course, the grass is greener here. You can charge more than they did there.

Senator CONRAD. Gordon.

Mr. SMITH. I don't know if I have the answer to those escalations to the cost, but as I drove here today, I thought about these questions that might come up.

And, you know, you talked about 1965 and what's happened since then. Number one—or I guess my main question is—and I'm not going to answer it, I'm just going to throw it out—what was the minimum wage in 1965? Another thing, have you ever been in to have your car repaired lately? I have, and I have seen a sign hanging up there that said: "Minimum labor charge per hour $20," I think. Maybe it was more than that. Now, I ask you, if you sat your car in that garage for 24 hours at 20 bucks an hour, that's $480. If you were a patient in an intensive care unit, you would have a nurse with you for 24 hours at how much? I think you might have a bargain in health care as compared to your car.

Mr. THOM. I would like to explain to you——

Senator CONRAD. If you'd identify yourself for the record again, sir.

Mr. THOM. Mr. Thom again. I think you can hear me.

Senator CONRAD. Yeah. I just wanted to make sure the stenographer gets the name so she gets it down right.

Mr. THOM. We're certainly not here to condemn the medical people. I'm condemning the cost of us paying, the method, of my wages coming out like this. My staff in my shop are paid above the minimum wage, but when I told you their family is $320 for Blue Cross and Blue Shield, their car payment, and their house, and their fuel, it's just about a thing of impossibility. One of them come up and said the other day, "I'm just going to quit it," and here we're paying 75 percent of it.

I surely don't criticize the rural doctors. I come from a rural town. We have a good hospital up there operating.

And I can't go on my figures too strongly on waiting for 2 years in Canada, but I do know of patients that have had cardiac problems, and they're in there just as fast as anybody else. But maybe a long-term treatment or something, it might take a little longer to get in. Winnipeg and Brandon, my two experiences are that there's not a very long waiting period if you're an emergency. Tell them you have a heart attack, get in quick.

Senator CONRAD. All right. We're going to have to move ahead, because we're running behind schedule now and we need to have a chance to hear from all of our witnesses, and I want to continue to give the audience here a chance to participate.

Next, we're going to hear from Ed Smith, former president of North Dakota Farmers Union, and a consumer witness, and Glenn Fornes of Minot, retired military officer. And, Glenn, if you would join in. We'll start with Ed and then go to Glenn, and then open it up for further questions and comments.

STATEMENT OF ED SMITH, FORMER PRESIDENT, NORTH DAKOTA FARMERS UNION, CHAIRMAN, SILVER-HAIRED EDUCATION ASSOCIATION, CHAIRMAN, AGING NETWORK OF NORTH DAKOTA

Mr. SMITH. Thank you, Senator. I appreciate having the opportunity to appear here today.

Senator CONRAD. Welcome.

Mr. SMITH. I'm sure I don't have the statistics to prove, you know, all the things that were said here earlier, but my concern, I guess, as a consumer, is that I represent the senior citizens from all over North Dakota. I serve as chairman of the Silver-Haired Education Association and chairman of the Aging Network in North Dakota, which represents all 53 counties and four Indian reservations. So I get around the State, and I get a lot of opportunity to talk to people about their problems.

And seniors in our State and the Nation live in fear of contracting some type of illness in their twilight years that would exhaust all of their savings. And they really are concerned, because they have lived—worked all their lives, and they find just in the last few years, they'll exhaust all their earnings and end up as paupers from the cost of the health care delivery system. I don't know where the cost comes from. Some say it's insurance. Some say it's this. Some say it's that. We just haven't found out what it really is and what's causing it. But I think that after all the planning that these people have made, it would seem to me, and I would think it would be criminal to take away what they have saved in their entire life and reduce them in their dignity. Because they have saved and done well, but all at once they have contracted some illness that is very catastrophic, and the whole family in turn is paupers.

With that announced cut of $64 billion from the Medicare Program that I heard on the radio the other day, it seems to me that's an astronomical figure to cut off already what I heard the people from the hospitals talking about here today. If they have been cut some before, it seems to me that $64 billion will be another tragic cut in medicare.

The United States is now at the crossroads, as I feel, in health care delivery. We're coming to a point where we're going to have to make a decision which road to take. And in listening to all of the comments here, I think a national health insurance policy of some sort has to be made right now. We cannot wait and use a Band-Aid operation. A Band-Aid operation, it seems to me, is a total catastrophe, because we have never really solved any of the problems of the hospitals and we have not solved anything on the health. It seems to me we're always trying to figure out how to get by just for another year. And I think we have come to the crossroads.

I think there should be a dual-pronged operation, which is probably the case in Canada and in all of the European countries. There's only two countries in the world, the United States and South Africa, that don't have a policy established. Now, why is it that we say all of these countries in the world are wrong, that we somehow are not doing the right thing here in America by asking for a socialized medicine, if you want to call it that.

Some people say socialization of medicare would be tragic. We have schooling systems in this country that are socialistic, if you want to call them that, publicly owned. Where sewer and water is publicly owned, that's socialistic, if you want to call it. I think we should be thinking about the medical delivery system on the same basis. Because, to me, it's more important to take a look at the medical care and the health delivery system than it is at our streets, sewer and water, and whatever you have.

So I feel that if we are going to take a look at this, we have to look at it on the basis that what is it that's causing the problem. And I'm not really sure. I have some people come to me, and they say, "Ed, there's really a problem here, because I go to the hospital and all at once, I get a bill from three different doctors. One doctor comes in and looks at whatever you call that sheet, looks at it, 'Good morning, how are you feeling,' walks out and charges 35, 40 bucks." And people cannot understand why this is. I would like to have the people here explain why this happens. And perhaps they have to have it to make the cost of operation work.

And the other one is that they say they like to see their free enterprise operate. Well, there's really no free market in the health delivery system. You go where you're absolutely trapped to go. If you live in a rural area, using an area like Rugby, if you want to use that example, those people have to go to the Rubdy hospital, belong to the HMO over there, and they do a good job. Something happens, they send then up here to Minot to more sophisticated machinery or whatever you have here in the hospitals that do a better job.

If you look at the industrial United States, or in agriculture, something that I know something about, you buy a big machine to do a better job, that's cheaper to run and cover more acres and do a better job. But you buy sophisticated machinery in the hospitals, it seems to me all it does in add more costs. More specialists, more costs, more specialists, and up goes the bill. This is where I think we always seem to run into cross purposes.

And I would say just this in closing—I don't want to spend any more time, because I don't have a lot of statistics here to prove. But in the dollars—if we spent all the dollars, put them all together, all the dollars that private, state, and Federal capital put together, the money we spend for the health delivery system for the United States was put in one batch like it in the Canadian provinces and in the Scandinavian countries, we would have a better delivery system. We would—of course, we would have contractual arrangements with the doctors in the hospitals, and it wouldn't be like it is today.

It seems to me that every time I hear somebody talk, it seems like it keeps changing. They are not sure what's coming up next year because the Federal government may not do them the right—or give them the right amount of money to run their hospital. If we had a Federal policy that was written at the top, and once established—as the lady said about Alberta, they have had many changes of government—Mr. Thom said the same thing—many changes of government, but the health plan stayed, and the people are satisfied.

So I would like to just say and follow up on the President's message in the State of the Union message when he said, "I want a kinder and gentler America." I would like to see it happen. Thank you very much.

Senator CONRAD. Thank you, Ed.

Next's we'll hear from Glenn Fornes, consumer witness from Minot.

STATEMENT OF GLENN FORNES, RETIRED MILITARY OFFICER, MINOT, ND

Mr. FORNES. Thank you for this opportunity, Senator, to bring the Senate hearing to us. It is a great break for everyone.

I asked for about 1 minute simply to point out to you that I did give some written testimony in regard to the health care system, of which I am a consumer, and I don't think it bears discussion here.

However, Ed mentioned his job as State chairman for Silver-Haired Education Association, Silver-Haired Assembly, and Aging Network, and he's my successor to this glorious position. I had it for about 3 years. It was a pleasure to turn it over to Ed, who had a great deal more experience in such a leadership role than I even did.

But I do want to remind you, Senator, that in about 1984, our Silver-Haired Assembly did pass a resolution in support of a national health insurance. It was presented to the assembly for consideration by a gentleman, one of our delegates, who had just returned from a trip to down under. While in Australia, he had received some treatment and was so well pleased and surprised at the cost to himself for treatment and cure—service for whatever ailment he had at the time, that he decided something should be done in the United States and in North Dakota.

So this resolution was passed. And when the information was presented to your predecessor, Senator Andrews, he put it on one of his survey forms. And wouldn't you know that the answers he received were 48 percent in favor of some sort of national health insurance system for everyone, 50 percent opposed, 2 percent undecided. Now, could we say that that's almost half and half? I would suggest to you, Senator, that if you were to try such a thing, perhaps the answer would be just a little bit different 4 or 5 years later.

And that's about all I have to say. I support Ed's comments. Thank you, sir.

Senator **Conrad**. Thank you very much. I appreciate that testimony.

I think what we will do is go next to the dean of the UND Medical School, Dean Ed James, who is with us, and then proceed to Dr. Rhonda Ketterling, who is a health care physician in Rugby, and then at that point open it up again to the audience for comments and suggestions.

So if we might, we are very fortunate tonight to have with us the dean of the University of North Dakota Medical School, Dean Ed James. It is a real privilege to have you here with us, Dean James. We very much appreciate the fact you have taken the time to share with us. And if you would please proceed.

STATEMENT OF EDWIN C. JAMES, PROFESSOR OF SURGERY, DEAN, UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE

Dean **James**. Thank you, Senator Conrad. And please excuse me tonight, ladies and gentlemen. I have a bad cold, and I wanted to leave my nose at home in Grand Forks before coming.

I am pleased to be here. I am, as Senator Conrad indicated, dean of the medical school, and I appear on behalf of the medical school and the situation I see with medical education in our teaching hospitals and our rural hospitals.

Our school of medicine is university based, community integrated, and as such is a very successful prototype of this school in this county. I think it's one of the best rurally-based, statewide medical schools in the United States.

We have four statewide campuses, each representing a major quadrant of our State. We have a small medical school by comparison with other States and private schools, with primary care, postgraduate residency training programs in family medicine, internal medicine, psychiatry, and surgery, in addition to pathology and flex residency programs. With the Family Practice Center and family medicine training program located in each of our four quadrants and the cities therein, we have managed to place 22.4 percent of our medical school graduates into family medicine during the past 8 years. And in this category, we rank near the top of the medical schools in this country in getting graduating students to track in family medicine rather than in the subspecialties of medicine.

UND School of Medicine uses 36 hospitals. These are—by comparison to other parts of the country, North Dakota is a very rural State, and even though some of them may not be considered rural hospitals, I like to look at them as such. In addition to the Veterans Administration Center Hospital in Fargo, we have teaching hospitals located in Grand Forks, Fargo, Bismarck, and Minot. Also the University of North Dakota School of Medicine uses 28 hospitals located throughout rural North Dakota for Phase III–IV medical student training. Most of these hospitals—and there are a few that are over 50 beds, and I think a few that may even be over a hundred beds—but most of these hospitals are 50 beds in size, or smaller, and by national definition then are very small rural hospitals. They have managed to maintain their viability by treating medicare patients. Even in our major teaching hospitals, medicare patient admission days average more than 40 percent for all patients. And in the hospitals in Minot, I believe the figure is probably over 50 percent.

The Prospective Payment System of medicare, which we have been talking about tonight, initially met with approval by many of the rural hospital administrators, because it was believed that this was a better payment system for patients than the previously complicated system of getting retrospective cost-based reimbursement. Although supportive as a whole, these administrators have been extremely critical because medicare PPS, Prospective Payment System payments have generally reflected an administrative policy of deficit reduction—deficit budget reduction and have not accounted equitably for yearly increases in the hospital market basket, previously alluded to by Mr. Strauch and others here tonight.

PPS payments to a hospital cover all inpatient operating costs, including room and board, radiologic and laboratory services, special care services, malpractice costs, capital expenses, and direct medical education costs. In addition, PPS payments include allowances for indirect medical education, which is funded through medicare, Part A, and have provisions included for hospitals with a disproportionate share of low income patients, although these provisions may be inadequate.

Differences in urban and rural adjustments standardized amounts for calculation of medicare payments account for an urban-rural reimbursement differential which averages minus 12.3 percent for rural hospitals. However, the difference in actual PPS payments through medicare may actually be as great as minus 30 to 40 percent for some hospitals. This may create very low or even overall negative operating margins for all but the largest of hospitals, depending on the case mix and percentage of medicare patients treated, severity of illness, length of stay, and other contributors.

Standardized amounts are adjusted in PPS payments to pay medicare's share of hospital costs associated with approved postgraduate residency training programs or medical education. In fiscal year 1989, the indirect teaching adjustment factor for PPS payments paid through medicare, Part A, is 7.7 percent. Qualifying hospitals are given these payments in one lump payment, based on the rather complicated formula involving the standardized amounts, the DRG weights, the number of residents in hospital beds. Adjusted factors enter into it, and so does the DRG rate index or case mix. The calculated indirect medical education adjustment is critical to the quality of care given to medicare patients. In other words, where you have medical education involved in hospital treatment of patients, the—it's a national fact that the quality of care is better than when you do not have educational programs.

In Memorandum 89-7, which is one of the attachments with my handout,[1] its Attachment B, from the Association of American Medical Colleges, medical schools, teaching hospitals, and academic societies were notified that President Reagan officially included in his 1990 budget a reduction in medicare education funding through Part A of $5 billion, including a reduction of this adjustment factor from 7.7 percent to 4.05 percent. What this really means is that the—of that $5 billion, $1 billion—a little bit over $1 billion will be reduced for payments of medical education in fiscal year 1990. My concern is if the formula changes or if there is a difference for funding in medical education to the hospitals located like in North Dakota, in Minot and so forth, that the programs that we're able to have in these hospitals will be compromised severely. President Bush also plans to have the same $5 billion reduction in his budget that President Reagan reported.

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[1] See prepared statement, p. 367.

The Association of Amercian Medical Colleges are asking the medical schools, the academic societies, the students, all of these people, to go to their Senators and Congress people and try to get the money for medical education reinstated. Also to include back into the budget the $5 billion as a whole that is being taken.

I encourage you, Senator Conrad, and Senator Burdick and Congressman Dorgan, to join the sponsors and cosponsors in the 101st Congress of the "Protect Medicare '90" Congressional Resolution. And this is included in my handout as Attachment D. This is a group of 5 Senators and 45 Congressmen who support protecting medicare and not reducing it in this fashion, so that the $5 billion will be let back in.

Lastly, a bill introduced in the Senate by Senators Bentsen and Dole to provide a national rate for hospitals would close the urban-rural gap in medicare patients. This is going to go into effect, if passed by the Congress, October 1, 1991, and that gap would be closed by October of 1994, with a 4-year transition. I think that this bill would help, if supported by the Congress, to—to provide emergency care, ambulance care, nursing support to rural hospitals. And it is hoped by the AAMC, the Association of American Medical Colleges, and medical schools, that there will be support in the Congress for that bill.

That's all I have to say, Senator Conrad. I would be happy to take any questions.

Senator **Conrad**. Thank you very much. I think we should probably allow the dean to leave. I think it would be a supreme irony if we have a health hearing and the health of the dean of our medical school is threatened as a result. That somehow seems to be counterproductive.

But let's just ask, does anybody have a question that they'd like to put to the dean? His written testimony is very complete and thorough. Any questions for the dean? All right. It looks like we're going to give you an early evening.

Dean **James**. Thank you very much, Senator Conrad.

Senator **Conrad**. Thank you very much for making the effort to be here.

[The prepared statement of Dean James follows:]

MEDICARE AND THE CRISIS OF MEDICAL EDUCATION IN RURAL HOSPITALS

PRESENTED BY

EDWIN C. JAMES, M.D., PROFESSOR OF SURGERY
DEAN, UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE
GRAND FORKS, NORTH DAKOTA

FEBRUARY 16, 1989

MEDICARE AND THE CRISIS OF MEDICAL EDUCATION IN RURAL HOSPITALS

February 16, 1989

PRESENTED BY

EDWIN C. JAMES, M.D., PROFESSOR OF SURGERY

DEAN, UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE,

GRAND FORKS, NORTH DAKOTA

Mr. Chairman and members of the committee, I am Edwin C. James, M.D., Professor of Surgery and Dean of the University of North Dakota School of Medicine, on whose behalf I appear before you this evening. I appear because of concern regarding funding for postgraduate medical education in North Dakota. Our School of Medicine is university-based and community-integrated and, as such, is a very successful prototype of this type of School. We have four (4) statewide campuses, each representing a major quadrant of our rural state. We are a small Medical School with primary care postgraduate residency training programs in Family Medicine, Internal Medicine, Psychiatry, and Surgery in addition to Pathology and Flex residency programs.

With a Family Practice Center and family medicine training program located in each of our four (4) campuses, we have averaged 22.4% placement of our medical school graduates into Family Medicine during the past eight (8) years and rank near the top of our country's medical schools in this category. In addition, almost one (1) of every two (2) physicians practicing in North Dakota in all primary care specialties have trained in our Medical School or its postgraduate programs.

The UND School of Medicine utilizes thirty-six (36) rural hospitals for its medical student, intern and resident training programs. In addition to the Veterans Administration Center Hospital in Fargo, there are a total of eight (8) major teaching hospitals located in Grand Forks, Fargo, Bismarck and Minot, which vary in size from 161-404 hospital beds. Also, the University of North Dakota School of Medicine uses twenty-eight (28) hospitals located throughout rural North Dakota for Phase III-IV medical student training. One of these locations is actually in Browning, Montana. Although these small rural hospitals vary in size and number of beds (22-129 beds), the majority are under 50 beds in size and, by National definition, are very small hospitals. They have managed to maintain their viability by treating Medicare and minority (e.g., Native American) patients. Even in our major teaching hospitals located in Grand Forks, Fargo, Bismarck and Minot, Medicare patient admission days average more than 40% for all hospitals and, in the hospitals in Minot, the figure is probably over 50 percent.

The Prospective Payment System (PPS) mandated by the Social Security Amendments of 1983 (Public Law 98-21) initially met with approval by many rural hospital administrators because it was believed that this was a better payment system for Medicare patients than the previously complicated system of getting retrospective cost-based reimbursement. Although supportive as a whole, these administrators have been extremely critical because PPS payments have generally reflected an administrative policy of deficit budget reduction, and have not accounted equitably for yearly increases in the hospital market basket. In addition, PPS payments also discriminate between urban and rural hospitals and include inequities in payments for outlier costs.

PPS payments to a hospital cover all inpatient operating costs including room (bed) and board, radiologic and laboratory services, special care services (ICU, CCU, OR), malpractice costs, capital expenses and direct medical education costs. In addition, PPS payments include allowances for indirect medical education (Medicare, Part A) and have provisions included for hospitals with a disproportionate share of low income patients. North Dakota citizens are becoming more elderly and, in years to come, disproportionate share (low income) patients will increase in number in our rural hospitals.

Differences in urban and rural adjusted standardized amounts for calculation of Medicare payments account for an urban-rural reimbursement differential, which averages -12.3% for rural hospitals. However, the difference in actual PPS payments may actually be as great as -30 to -40% for some hospitals. This may create very low or even overall negative operating margins for all but the largest of hospitals, depending on the case mix or percentage of Medicare patients treated, severity of illness, length of stay and other contributors.

Standardized amounts are adjusted in PPS payments to pay Medicare's share of hospital costs associated with approved postgraduate residency teaching programs or medical education. In FY 1989, the indirect teaching adjustment factor for PPS payments, paid through Medicare, Part A, is 7.7 percent. Qualifying hospitals are given these payments in one lump payment, based on a rather complicated formula involving standardized DRG weights, number of residents and hospital beds, adjusted DRG weights and DRG rate index or case mix (Attachment A). The calculated indirect medical education adjustment is critical to the quality of care given to our Medicare patients and impacts greatly on our ability to have Medical School teaching programs in North Dakota.

In memorandum #89-7 (Attachment B) from the Association of American Medical Colleges (AAMC), medical schools, teaching hospitals and academic societies were notified that President Reagen officially included in his FY 1990 budget report of January 9, 1989, a proposal that would result in an estimated $5 billion reduction in Medicare payments to hospitals and physicians, **including a reduction in the indirect medical education adjustment to 4.05 percent**. A reduction of the indirect medical education adjustment from its current level of 7.7% to 4.05% would reduce payments for medical education Nationwide by $1.02 billion in FY 1990.

Depending on the formula calculation used (e.g., whether it is changed or altered significantly), the effect on residency programs in our Medical School and our rural teaching hospitals could be disastrous. The apparent effect on graduate medical education is to reduce funding for the costs of classrooms and supervision by teaching physicians. President Bush's budget appears to retain President Reagen's $5 billion reduction in Medicare payments to hospitals and physicians including the $1.02 billion reduction earmarked for medical education.

In memorandum #89-1, dated January 9, 1989, the AAMC requested that deans, teaching hospitals, academic societies and student representatives notify their Senators and Congressmen to support a critical "Sense of the Congress" resolution (Attachment C) that payments to teaching hospitals under Medicare should be protected in FY 1990. Not only are our teaching hospitals in North Dakota under the same budgetary pressures as other hospitals to provide efficient, quality care, they must fulfill their unique mission with our School of Medicine to educate our students and residents as the future physicians of our state. Also, in order to have adequate Family Practice Centers in our four (4) major campuses, we need to protect the indirect and direct medical education payments for residents and physician teachers, which are threatened through proposed reductions in funding for Medicare, in both Parts A & B, to teaching hospitals.

I encourage you to join the sponsors/cosponsors in the 101st Congress of the "Protect Medicare '90" Congressional Resolution (Attachment D). You will note that one of the Senate cosponsors is Senator Pressler from South Dakota. It is hoped that you will encourage support from Senator Burdick and Congressman Dorgan for this important resolution to protect our University School of Medicine teaching programs and quality health care delivery for our senior citizens. Congress should not attempt to balance the budget by reducing the indirect medical education adjustment below the 7.7 percent. Congress should also protect the payments for teaching of residents provided for in Medicare, Part B. Maintaining payments for outpatient and physician services at the levels specified by current law are necessary to ensure that the decisions on whether to treat patients as inpatients or outpatients are based primarily on medical appropriateness rather than level of payment.

Lastly, a bill introduced in the Senate by Senators Bensten and Dole to provide a National rate for hospitals would close the urban-rural gap in Medicare payments to hospitals previously mentioned by October 1, 1994. A 4-year transition to a single National rate would begin October 1, 1991. This bill would provide additional Medicare funding for undergraduate nursing education in rural hospitals and serve a number of other functions, including staffing ability and demand for ambulatory or emergency services. It is hoped that yourself, Senator Burdick, and Congressman Dorgan will provide needed critical support for this bill as it is debated in Congress.

ATTACHMENT A

MEDICAL EDUCATION FUNDING FOR HOSPITALS

INDIRECT MEDICAL EDUCATION ADJUSTMENT

* Adjustment is reimbursed through Medicare Part A. Unless salaried hospital physicians (emergency room) are on board, then Part B is used for additional educational support.

* This adjustment is reimbursed on an on-going basis with every DRG case.

* This adjustment is provided because teaching hospitals serve as referral centers and attract a disproportionate number of more costly Medicare patients with higher DRG weights. Congress has provided for this adjustment through a Indirect Medical Education Adjustment formula which is very complex, is hospital specific, and correlates numbers of residents with the number of available (usable) beds.

* INDIRECT MEDICAL EDUCATION ADJUSTMENT FORMULA:

$$1.89 \times \left[\left(1 + \frac{\text{\# of Residents}}{\text{\# of Available Beds}} \right)^{.405} - 1 \right]$$

This formula should be equal to approximately 7.7% (.077).

* The resultant figure from this formula is used in the following manner:

Formula % X Standardized DRG rate = Indirect Medical Ed. Adjust

Indirect adjust + Standardized DRG = Adjusted DRG rate

Adjusted DRG rate X DRG rate index (case mix) = Total reimbursement.

	CURRENT 7.7% EXAMPLE: A	PROPOSED 4.05% EXAMPLE: B
Formula Percentage	7.7%	4.05%
Standardized DRG rate	X $3,000.00	x $3,000.00
Indirect Medical Ed. Adjust.	$231.00	$121.50
Standardized DRG rate	+ $3,000.00	+ $3,000.00
Adjusted DRG rate	$3,231.00	$3,121.50
DRG rate index (case mix)	X 1.5	1.5
Total reimbursement	$ 4,846.50	$ 4,682.25
Total reimbursement w/o adjust	- 4,500.00	4,500.00
Benefit from Indirect Med Adj.	$ 346.50	$ 182.25

Formula, DRG rates, and rate index are variable for each hospital

ATTACHMENT A (cont)

INDIRECT MEDICAL EDUCATION ADJUSTMENT cont.

* To arrive at Resident FTE counts, the hospital can account for both the time the resident spends in the hospital and for the residents out-patient ambulatory care time, if the hospital puts all, or a substantial portion of the funding for the program. This is from the Federal Register effective as of July, 1987. BC/BS averages out the resident count over an annual basis. A formal contract with the affiliated university is a key to verifying funding agreements.

* BC/BS verifies the formula calculation for the hospital.

* The indirect adjustment is maximized through the case mix adjustment.

DIRECT MEDICAL EDUCATION PAYMENTS

* The hospital also can be reimbursed for their direct costs associated with a residency program. This may include such expenses as faculty and staff salaries, stipends, insurance, food, space, supplies, etc. Medicare will reimburse these costs on the same ratio as the percentage of Medicare in-patient days relates to the total in-patient days in the hospital.

* The direct payments can be reimbursed up to a limit per resident. The figure of $20,000 per resident appears to be the cap. Hospitals can maximize their medical education payments by going up to the cap on direct expenses.

* The direct medical education payments are paid through the medicare cost reports, on a periodic basis.

ATTACHMENT B

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #89-7 January 31, 1989

TO: Council of Deans
Council of Teaching Hospitals
Council of Academic Societies

FROM: Robert G. Petersdorf, M.D., President

SUBJ: Analysis of President Reagan's FY 1990 Budget

President Reagan officially released his FY 1990 budget January 9. The highlights of this budget include:

- proposals that would result in an estimated $5 billion reduction in Medicare payments to hospitals and physicians, including a reduction in the indirect medical education adjustment to 4.05 percent and a PPS update factor of 3.2 percent;
- a proposal to eliminate funds for health professions training programs and to reprogram $29 million in FY 1989 funds to enhance the HEAL Student Loan Insurance Fund.
- an increase of 5.3 percent for NIH funding and 12.2 percent for research and research training at ADAMHA, including AIDS;
- $1.6 billion for the Public Health Service for AIDS research, education, and prevention activities; and
- a 2 percent increase for VA medical care and hospital services and a 6 percent decrease in medical and prosthetic research funding. The budget also includes a $1 billion supplemental request for FY 1989 for the VA, none of which is targeted for the medical care or research accounts.

Attached is a summary of the president's budget for the major programs of interest to the Association. Individuals who desire additional information should contact Catherine Cahill (Medicare and Medicaid), Sarah Carr (Health Manpower), Leslie Goode (VA) or Dave Moore at (202) 828-0525.

Attachment

ATTACHMENT C

Resolution to Protect Medicare

101st CONGRESS
1st Session

To express the sense of the nation's hospitals with respect to continuing reductions in the Medicare program.

Whereas Medicare is an integral part of our Nation's Social Security System;

Whereas Medicare provides needed health insurance coverage for 33 million of our Nation's most vulnerable elderly and disabled citizens;

Whereas the Medicare Hospital Insurance Trust Fund is expected to produce an annual net surplus for the Medicare Part A program through 1998;

Whereas Medicare has been the target of budget reductions for each year since fiscal year 1982;

Whereas the General Accounting Office (GAO) recently estimated in the fiscal years 1981-1986 Medicare payments to hospitals had been reduced by $17,300,000,000 and there have been additional substantial cuts in Medicare Part A expenditures included in the Omnibus Budget Reconciliation Acts for fiscal years 1987, 1988, and 1989;

Whereas the Prospective Payment Assessment Commission in its March 1, 1988 testimony before the House Ways and Means Committee stated that in 1988 it is likely that the average PPS margin will fall below zero; and

Whereas further budget reductions threaten the financial viability of the delivery system serving Medicare beneficiaries:
Now, therefore, be it

Resolved by the nation's hospitals, That it is their sense that Medicare payments to hospitals for fiscal year 1990 not be reduced below current law levels for fiscal year 1990 to enable the Medicare program to meet the necessary costs of assuring the 33 million elderly and disabled beneficiaries continuing access to high quality health care services.

And be it further resolved that additional funding be provided to ensure adequate and equitable Medicare payments to hospitals.

ATTACHMENT D

"PROTECT MEDICARE '90" CONGRESSIONAL RESOLUTION SPONSORS/COSPONSORS IN 101ST CONGRESS

U.S. Senate

Daschle, Thomas A. (D-SD)
Durenberger, Dave (R-MN)
Kassebaum, Nancy Landon (R-KS)
Mikulski, Barbara A. (D-MD)
Pressler, Larry (R-SD)
Simon, Paul (D-IL)

House of Representatives

Bates, Jim (D-CA)
Borski, Robert A. (D-PA)
Boxer, Barbara (D-CA)
Collins, Cardiss (D-IL)
Costello, Jerry (D-IL)
Courter, Jim (R-NJ)
Craig, Larry E. (R-ID)
Crockett, Jr., George W. (D-MI)
DeFazio, Peter A. (D-OR)
deLugo, Ron (D-VI)
Derrick, Butler (D-SC)
Dymally, Mervyn M. (D-CA)
Emerson, Bill (R-MO)
Erdeich, Ben (D-AL)
Frank, Barney (D-MA)
Gordon, Bart (D-TN)
Grant, Bill (D-FLA)
Henry, Paul B. (R-MI)
Johnson, Nancy L. (R-CT)
Johnson, Tim (D-SD)
Kennedy, II, Joseph P. (D-MA)
Kolter, Joe (D-PA)
Luken, Thomas A. (D-OH)
Martin, David O'B. (R-NY)
Martinez, Matthew G. (D-CA)
Moakley, Joe (D-MA)
Mrazek, Robert J. (D-NY)
Murphy, Austin J. (D-PA)
Oakar, Mary Rose (D-OH)
Oberstar, James L. (D-MN)
Olin, Jim (D-VA)
Owens, Major R. (D-NY)
Patterson, Elizabeth J. (D-SC)
Petri, Thomas E. (R-WI)
Rhodes, III, John J. (R-AZ)
Rinaldo, MAtthew J. (R-NJ)
Roe, Robert A. (D-NJ)
Rowland, John G. (R-CT)
Saxton, H. James (R-NJ)
Schneider, Claudine (R-RI)
Traficant, Jr., James A. (D-OH)
Valentine, Tim (D-NC)
Whittaker, Bob (R-KS)
Young, C.W. Bill (R-FLA)

Senator CONRAD. Next, we are going to hear from Dr. Rhonda Ketterling, the president of Johnson Clinic of Rugby.

And let me just announce that my intention is that after Dr. Ketterling, we would open it for questions and comments from the audience, and after that we would hear from Dave Remillard, the executive director of the North Dakota Health Care Review, and Dr. Steve Podrygula, and then we will end with Dr. Robert Wentz, North Dakota state health officer in Bismarck, the chief health officer of the State of North Dakota.

Dr. Ketterling, welcome.

STATEMENT OF DR. RHONDA KETTERLING, PRESIDENT, JOHNSON CLINIC, RUGBY, ND

Dr. KETTERLING. Thank you. I would like to thank you, Senator Conrad, for inviting me to share my perspective on medicare reimbursement as a medical health care provider. I want to summarize my written testimony very briefly, and I have made a few notes as some of the questions have come up about some things I would like to respond to in that regard, as being a provider of rural health care.

I represent the medical community of Rugby, North Dakota, which is a rural community of about 3500 people. The Johnson Clinic and the Good Samaritan Hospital are the sole community providers of health care. Rugby has enjoyed continuous medical care since 1910. I am a board certified internist and assistant professor of internal medicine for the Northwestern Campus of UND School of Medicine. I also serve as chief of staff of the Good Samaritan Hospital. I am currently president of the Johnson Clinic, and the medical director of the Heart of America HMO.

Rather than entitle these hearings "The Crisis in Rural Health Care," they might have been called "The Decline and Fall of the Rural Hospital." Of the more than 300 U.S. hospitals that have been forced to close since 1983, roughly half of those have been in rural areas. There are currently 2700 rural hospitals in the United States, and as you have heard, about 600 of them are in danger of closing their doors. Of the 81 hospitals that closed last year, 43 of them were rural.

Who do these people serve or who do these hospitals serve? Twenty-four percent of the U.S. population lives in a rural area. Twenty-nine percent of the 30 million people who are over age 65 in our country live in a rural area. The elderly account for two-thirds of the patients in rural hospitals as opposed to one-third in urban facilities. In Rugby's Good Samaritan Hospital in 1988, 68 percent of our acute care patients were medicare.

Why have these rural hospitals closed? I think it could be summarized in one statement. We have seen the enemy, and it is called DRGs. This formidable bureaucratic creation has been the cause of the closing of many rural as well as urban hospitals. Diagnosis Related Group set flat fees for 477 medical conditions. Hospitals who are treating patients for a rate lower than medicare reimbursement keep the difference. However, hospitals must swallow the loss on most cases that end up costing more than the DRG system paid.

If you are 65 and you happen to be hospitalized with pneumonia, no matter how ill you are, and you come to the Good Samaritan Hospital, we have $5,859.78 to treat you. If you develop any number of complications, which are not uncommon in the elderly, who frequently have multiple medical diagnoses, the hospital eats the cost. This excess cost can be a true mouthful. In 1988, the total medicare discount absorbed by the Good Samaritan Hospital in Rugby was $678,000. In the month of July, we lost $56,000 on just four patients. And I can top the fellow that was here who lost $12,000. We lost $100 thousand on one patient in October. He lived.

If a person dies in 13 hours, you get paid the same if they had stayed 13 weeks. Death has become the most cost effective treatment.

Rural hospitals have been hit doubly hard by DRGs. Urban hospitals are able to shift more of their costs on their payers, while rural hospitals are more likely to lose money because of their dependence on medicare. In 1986, the profit rates for urban hospitals were 10.82 percent, while rural hospitals averaged a lost of 0.69 percent. One out of ten rural hospitals last year had a loss of 20 percent.

There's a tremendous loss of money from the rural American health care system, and this is due entirely to a two-tiered system of medicare reimbursement. Congress stacked the cards against rural providers by adopting two sets of DRGs, one for urban and one for rural hospitals. Reimbursement to a rural hospital can be as much as 50 percent less than an urban hospital for the same DRG. All recipients pay the same premium, however, medicare patients in rural areas are subsidizing the medical care of all urban senior citizens. The amount exceeds $18 billion a year.

The inequity in reimbursement doesn't apply just to urban versus rural hospitals, but urban versus rural physicians. Federal reimbursement favors urban physicians, particularly specialists. Apparently, Congress thinks that the big city doctors are the really smart guys and we rural physicians are a bunch of second-rate hicks. The medicare system reimburses urban physicians 40 percent more than urban physicians when similar specialties and similar practices are compared. The system is truly archaic.

Rural clinics and hospitals see a higher percentage of patients who get reimbursed by medicare. They depend upon that income to keep up with the high standards that patients expect and deserve. Lower reimbursement rates, however, make it unfeasible to purchase the high-tech equipment and supplies necessary to keep up with these standards. If high quality medical care and easy access are our main goals, then the inequities in reimbursement will have to be corrected as soon as possible.

It would seem to me that the answer to helping to solve the dilemma is fairly simple. You abolish the payment disparity for the 240 different medicare areas, get rid of the payment disparity for the different specialties, and have only one payment schedule for medical services.

This is a truly difficult problem. It's a multicomponent problem. I think everyone is looking to point a finger at one person or the other or the Federal government. People are looking to point it at hospitals, physicians, technology. And not all of us are guilty. And

I would submit that one of the biggest—several of the problems are greed and unrealistic expectations by the public.

People raise their eyebrows when you talk about rationing health care, but it's going to be happening in this country eventually. It's a political issue that a legislator would never want to open his mouth about because they would never get a vote. But the simple truth is we can't afford to keep transplanting everybody. Not everybody can have a heart transplant, a lung transplant, a liver transplant, a kidney transplant. You can't keep Grandma alive until she's 92 with artificial means. In Great Britain, if you happen to lose your kidneys and you have to have dialysis and you happen to be over the age of 65, it's just too bad. If you can pay for dialysis out of your pocket, great, you can have it. If you can't, too bad, you can go home and die.

And that's just exactly what's going to cruise down the road in our country as well. It may be a long time coming, but I think people are going to have to truly adjust what they expect out of the health care. Not everybody that walks into my office with a headache can demand to have a CAT scan or an MRI scan and threaten that they're going to sue me if they don't get it. Those kind of reactions by the public towards physicians have helped to escalate the cost of health care.

Lest you think I think it all belongs to the patient, the problem, I think physicians have gotten pretty darn greedy. I don't really think there's a physician who is worth half a million a year, and there are a number of them who make that kind of money.

Senator CONRAD. How about a baseball player?

Dr. KETTERLING. I also don't think a baseball player is, either. But the sad part is that we are responsible for that, too. We let them get paid a million dollars a year and don't grutch about it at all. In fact, we'll just go out and buy a little more Coors or Milwaukee Light or whatever it is they—whoever supports them.

The gentleman brought up a very good point here about specialist adding to the costs of the bill. That's very true. Bigger is not always better. However, in my experiences, if you see a patient for a problem and you don't have that diagnosis for them in the first visit, by God, they're asking you to get a referral to go down the road to see the specialist rather than coming back again. So some of it, you know, goes both ways.

Thank you for giving me the opportunity to come. I didn't mean to add the last part until I got a little riled up.

Senator CONRAD. Yes; I can see that you're somebody that's willing to express themselves.

Dr. KETTERLING. Yeah.

Senator CONRAD. I have to bring you to Washington. You can testify. The budget committee could use a little dose of that. Rhonda, if you would stay up. I think we should give this group a chance to have at you.

[The prepared statement of Dr. Ketterling follows:]

STATEMENT BEFORE THE SENATE BUDGET COMMITTEE

MEDICARE AND THE CRISIS IN RURAL HOSPITALS

Minot, North Dakota

Rhonda L. Ketterling, M.D.
President, Johnson Clinic, P.C.
Rugby, North Dakota

I would like to thank Senator Conrad and the members of the Senate Budget Committee for inviting me to share my perspective on the crisis in rural health care as it pertains to Medicare reimbursement.

I represent the medical community of Rugby, North Dakota, a rural community of approximately 3500 people. The Johnson Clinic and Good Samaritan Hospital are the sole community providers of health care. Rugby has had continuous medical care since 1910. I am a Board Certified Internist, an Assistant Professor of Internal Medicine in the Northwest AHEC of the UND School of Medicine, the Chief-of-Staff of Good Samaritan Hospital, President of the Johnson Clinic, P.C. and Medical Director of the Heart of America HMO.

Rather than entitle these hearings the "Crisis in Rural Health Care", they might have been called "The Decline and Fall of the Rural Hospital". Of the more than 300 U.S. hospitals that have been forced to close since 1983, roughly half have been in rural areas. There are currently 2,700 rural hospitals in the United States, 600 of them are in danger of closing their doors. Of the 81 hospitals that closed last year, 43 were in rural areas.

Who do these hospitals serve? Twenty-four percent of the U.S. population lives in a rural area. Twenty-nine percent of the thirty million people over age 65 in our country live in a rural area. The elderly account for 2/3 of the patients in rural hospitals as opposed to 1/3 in urban facilities. In Rugby's Good Samaritan Hospital in 1988, 68% of our acute care patients were Medicare.

Why have these rural hospitals closed? It can be summarized in the statement, "we have seen the enemy, and it is called DRG's" (diagnosis related groups). This formidable bureaucratic creation has been the cause of the closing of many rural, as well as urban hospitals. Diagnosis related groups set flat fees for 470 medical conditions. Hospitals treating patients for a rate lower than Medicare reimbursement keep the difference. However, hospitals must swallow the loss on most cases that end up costing more than the DRG system paid. If you are over 65 and hospitalized with pneumonia, no matter how ill you are, the Good Samaritan Hospital has $5,859.78 to treat you. Should you develop any number of complications, which are not uncommon in the elderly, who frequently have several major medical diagnoses, the hospital eats the excess cost. This excess cost can be quite a mouthful. In 1988, the total Medicare discount absorbed by Good Samaritan Hospital in Rugby was $678,000.00! In the month of July, we lost $56,000.00 on just four patients, and $100,000.00 on a single patient in October! If a person dies in 13 hours, you get paid the same as if they had stayed 13 weeks. Death has become the most cost effective treatment.

The loss of large amounts of money through the DRG system is not unique to Rugby, but rather a common problem under this inequitable system. Rural hospitals have been hit doubly hard by DRG's. Urban hospitals are able to shift some DRG losses to other payers, while rural hospitals are more likely to lose money because of their dependence on Medicare.

The Inspector General for the Department of Health and Human Services recently stated that the 1986 profit rates for urban hospitals was 10.82%, while rural hospitals averaged a loss of 0.69%. One out of 10 rural hospitals had a loss of 20% last year. If the present trend continues, more and more rural hospitals will be forced out of business, leaving a lack of facilities available to care for our rural population.

There is a tremendous loss of money from the rural American health care system, due entirely to a two-tiered system of Medicare reimbursement. Congress stacked the cards against rural providers by adopting two sets of DRG's, one for urban hospitals and another for rural. Reimbursement to a rural hospital can be as much as 50% less than an urban hospital for the same DRG.

All Medicare recipients pay the same premium, but seniors in urban America seem to be entitled to a higher rate of reimbursement for their health care than seniors in rural America. Thus, Medicare patients in rural areas are subsidizing the medical care of all urban senior citizens. The amount exceeds eighteen billion dollars a year! This inequity in reimbursement has existed for over 23 years, i.e. since the conception of Medicare and Medicaid in 1965. In that time span, the billions of dollars that have been transferred from rural America to urban America is inconceivable. Certainly this should be considered as a factor that may be responsible for the rural health care crisis that now exists.

The inequity in reimbursement doesn't apply to just urban vs. rural hospitals, but urban vs. rural physicians. Federal reimbursement favors urban physicians, particularly "specialists". Apparently congress thinks that the big-city doctors are the really smart ones and we rural physicians are a bunch of second rate hicks! The disparity in reimbursement can be as great as 700%! Why does a physician in New York deserve a higher rate of reimbursement than a physician in rural North Dakota for the same service? We are expected to deliver high quality care, as are our urban counterparts, but we are to be reimbursed as if we provided less. The U.S. Medicare system reimburses urban physicians 40% more than rural physicians, when similar specialties and similar practices are compared. The system is archaic.

The disparity between urban and rural reimbursement was/is based on the assumption that it costs less to deliver health care in a rural setting. This is a gross misconception. The average total practice cost is higher for a rural setting than urban. As a percent of overall income, the highest overall costs are associated with rural practices (39.8%), followed by suburban practices (38.8%), and finally, urban practices (36.9%).

In rural hospitals, the occupancy rate has fallen from 60% to 28%, and in hospitals with fewer than 50 beds, the average occupancy rate is 18%. At the same time, the cost of running a rural hospital has increased more than twice the market basket rate in the last two reported years.

Retention and recruitment of primary care physicians to rural areas is becoming more arduous each year. The number of rural physicians in this country could drop by as much as 25% in the next five years. Rural physicians see 20% more patients in their offices than do urban physicians. They work longer hours, are on call more often and are reimbursed less. All of these factors make it more difficult to attract "quality" physicians to rural areas. In fiscal 1988, the Johnson Clinic and Good Samaritan Hospital spent $29,000.00 for recruitment of physicians without any success. Even the graduates of our own medical school's program can't be pried out of the urban environment.

Some areas that are experiencing physician shortages have responded by training and utilizing Physician's Assistant and Nurse Practitioners. However, reimbursement for their services has been sharply reduced. Unfounded and unwarranted federal and state regulations have made it financially impractical for rural clinics to utilise their services. This further decreases the availability of medical services to the rural population.

Rural clinics and hospitals see a higher percentage of patients who get reimbursed by Medicare. They depend on that income to keep up with the high standards that patients expect and deserve. Lower reimbursement rates, however, make it nearly unfeasible to purchase the high tech equipment and supplies necessary to keep up with these standards. If high quality medical care and ready access are our main goals, then the inequities in reimbursement will have to be corrected as soon as possible.

The core of the problem is the nationwide move to contain health care costs. Total U.S. health care costs have increased from 6% of the GNP in 1974 to 12% in 1988. Some analysts project that health care costs will triple by the year 2000. The single biggest player in health services is Medicare, with an annual cost of about 80 billion dollars. The question is who gets less? The pie can only be split so many ways.

It would seem that the answer to helping solve the dilemma is fairly simple. Abolish the payment disparity for the 240 different Medicare areas, get rid of the payment disparity for the different specialties, and have only one payment schedule for medical services.

If a national relative value index or national fee schedule was used that had only one price for each service, and the price was at the Adjusted Community Rate (ACR), and if all Medicare patients who pay the exact same premium would get the exact same reimbursement, this could save the federal government billions of dollars yearly.

Every effort possible should be made to simplify this cumbersome, archaic and unfair system of reimbursement, allowing the rural health care system to devote its resources to providing health care, instead of trying to figure out an incomprehensible reimbursement process.

Thank you for the opportunity to testify on behalf of rural health care providers.

Respectfully submitted,

Rhonda L. Ketterling, M.D.

Rhonda L. Ketterling, M.D.
President, Johnson Clinic, P.C.

Senator **Conrad**. One thing I wanted to indicate, you made the—a statement that apparently Congress thinks that urban doctors are smart and rural doctors aren't so smart, and that must explain the differential. Let me just express to you that, frankly, a big part of the problem is simple politics and simple numbers. Because we have a House of Representatives that is based on population, and, obviously, we have more urban Members of the House than we do rural. And in the fights that occur, what happens is very simple. The Senate, which is based on two per State, wants even levels of payment between rural and urban. And the House, which disproportionately represents urban areas, wants to protect their turf and they don't want an even payment between rural and urban. And it gets down to a very simple fight, a political fight. They control the House, and we have got about an even standoff in the Senate, and so the urban boys win. And that's just a hard reality of what we have to deal with. And we're going to have to get very, very tough to have a chance to eliminate this differential. I mean, so tough that we say nothing is going to happen unless we get treated fairly and equitably. And that's really where we're at.

With that aside, let me just open it to the audience for questions, comments. Rhonda has said some things that are certainly thought provoking. I think she made a rather powerful statement of death has become the most cost effective treatment. And thank goodness doctors have not resorted to that as a solution.

Ms. **Spanjer**. I'm Denise Spanjer with the North Dakota Farmers Union. That's S-p-a-n-j-e-r. I don't know why it's always wrong, but it is.

At any rate, I agree with many of the things that you said, Dr. Ketterling, and everyone here has, I think, ripped off my testimony that I have already submitted to the Senator's office. But I appreciate the open-mindedness of all the individuals that have spoken this evening, especially yours, in that we need to look at an overall viewpoint of rural health, of health of the country. And I guess what we have to decide is what is our goal? Is our goal a community of the United States that has adequate health care for its citizens? Is that our overall goal? Or is the goal to continue to divide the country by the urban-rural types of situations or the people who have the numbers are the ones that are important?

So I guess to underline that, if we could have an overall comprehensive study of health care, period, and how it treats the individuals of the United States and the citizenry of our United States, I think that's what really has to be our goal. And in the process of that, we're going to have our budget being the overall one that's the winner. It has to be. Because if we have people who can continue to pay of their health care, be healthy individuals, contribute to society, and so on, it has to come out even in the balance. So that's what I have to say.

Senator **Conrad**. All right. Would you like to respond to that?

Dr. **Ketterling**. Well, I do agree with her, as far as I think, yes, our goal as a physician is that good health care is available to everyone in this country, from the bottom on up. I think there have to be certain standards set about what that is going to be. Does that mean everyone is—our goal is that everyone can have a heart transplant if they want it, or does that mean that basically they're going to be provided good basic medical care, immunizations, counseling on preventive health care, that type of thing? Surgical procedures if they need it.

Ten years ago, I would have bit my tongue off if I even said the words "socialized medicine." It was just like—and even in medical circles now, if you say anything about socialized medicine or national health plan, I think you probably would be quickly ostracized. And part of that is because the pie is so big, and everybody only gets so much of that pie. And physicians, obviously, want to protect their income, hospitals need to protect their bottom line. And it's a very difficult problem.

Senator **Conrad**. Other questions or comments that people might want to make? Yes, sir.

Mr. **Effertz**. My name is Stan Effertz. I am a retired citizen of the city of Minot. Have been here for about 40 years.

I just went and paid my income tax the other day. I had them do a little survey of the next year, and those of you who have gray hair in the audience, you better have them take a little survey for you, too. Because medicare is going to end up costing you quite a little money for catastrophic care if you have any income. As a matter of fact, $22.50 for every $150 of tax liability that you have got, and that's just [illegible] 1989. By 1993, that goes up to 42 bucks.

So I think we've got to go back to Will Rogers and some hillbilly logic, Senator. I think you're either going to have to go to a socialized medicine plan or support our government in getting back to supporting programs that deal with your right to life and your right to liberty and your right to pursuit of happiness and get out of this business of redistribution of wealth.

Senator **Conrad**. All right. Others that have a question or comment that they would want to make?

Yes, sir. Mr. Didier, I think is——

Mr. **Didier**. Yes; just a quick question, Senator. I believe that the percentage of gross national product for health care in this country is 11½ to 12 percent.

Senator **Conrad**. Yeah. For 1987, it was 11.1 percent.

Mr. **Didier**. I would like to ask if you know what the percentage of gross national product of health care for the Canadian government is.

Senator **Conrad**. I think it's 8.6 percent.

Mr. **Didier**. OK. I'm not sure of that figure, but I heard it was significantly more.

Senator **Conrad**. No No, it's significantly less. We have the highest percentage of GNP for health care of any industrialized country in the world, by far.

Mr. **Didier**. Thank you.

Senator **Conrad**. And going up. Going up dramatically. We're headed for 15 percent of GNP.

Yes, sir, in the back.

Mr. **Baumgartner**. Senator, my name is Mike Baumgartner, the president of the Presentation Center in Rolla.

Senator **Conrad**. Welcome.

Mr. **Baumgartner**. Thank you. I would like to—Medicare is very important. We only have 40 percent of our residents on medicare, our patients, but another 40 percent are on medicaid, a part of Senator Dole's and Senator Benson's program. They're saying that facilities with 70 percent or more with medicare will receive extra funds. If that could be worded medicare and/or medicaid, our facility would appreciate that. Sixty percent of our patients are Native American.

Senator CONRAD. All right. Thank you very much.

Other questions or comments that people might want to—yes, ma'am.

Ms. TRZPUC. I'm a student, Shelly Trzpuc. And I have studied this year extensively on socialized medicine, health rationing, and other health programs.

First of all, I would like to answer Mr. Smith on the cost of just reading sheets. Right now what's happening is the doctors are getting paid more because they have to—right now in the United States, citizens expect the highest technology, they expect the best care given. And in Canada, they just assume they're getting the care for the right health care. And right now what's happening is the cost of machines and the specialists, the United States citizens are demanding this, and in demanding this, it raises the health care cost significantly. Also, Canadian physicians are leaving because of the decreased pay in this socialized medicine system.

And I agree that right now, South Africa and the United States are the only countries in the world with some forms, but also rationing is going on in Canada, because citizens are being denied. As Mrs. Ketterling said, kidney dialysis and heart transplants, these are unheard of. Rationing is going on. It's decided on age, et cetera. And right now, even in the United States health rationing is taking place. Sixty thousand women and children, 567,000 senior citizens were denied medical services. Also hospital dumping is taking place, and people are switching patients in big cities because they can't afford to keep these patients who don't have ample health care. Therefore, right now rationing in the United States is going on.

Also, we have in the United States PPS, DRG, HMO, supplemental, medicare, medicaid, private sector, and other private insurance policies, and the competition raises the cost and increases the loss of access.

So we can clearly see that we need an overall socialized medicine policy, but we have to make sure of access and people aren't waiting for these health services, as they are in Canada. Rationing is going on in Canada. We have to make sure that that does not happen in the United States with a socialized or national insurance policy.

Also, we can see that Mr. Kennedy right now in the United States Congress has proposed a bill to Congress, and this is for a national health insurance. This was recently blocked or banned. So we have to convince Congress of the need of this health policy. That's all I have to say.

Senator CONRAD. All right. Thank you.

Rhonda, any comments that you would want to make?

Dr. KETTERLING. She's got to be Dr. Trzpuc's daughter. I notice that she talked about the business of Canada and rationing, and I notice some heads going no, that doesn't happen. It wasn't too long ago, Rugby was doing a booming business in CAT scans from Manitoba because people had to wait so long to get a CAT scan of their brain that they were coming down from Brandon to North Dakota at the rate of about 2 to 3 a day from the neurologist up there. That got cut off not too long ago because of some of the problems of reimbursement. They had to pay out of their pockets a little bit more than I think they wanted to. But they were telling us there were 2- and 3-week waiting lists just to get an elective CAT scan done in that province because the only CAT scanner that was available is in Winnipeg. So it does go on.

Senator **Conrad**. Rhonda, thank you very much for participating in our hearing tonight.

I am going to go ahead to Dave Remillard, the executive director of the North Dakota Health Care Review, and Dr. Steve Podrygula, psychologist, from Minot. If both of you will come, and we'll start with Dave and then go to Dr. Podrygula.

STATEMENT OF DAVE REMILLARD, CHIEF EXECUTIVE OFFICER, NORTH DAKOTA HEALTH CARE REVIEW, INC.

Mr. **Remillard**. Good evening, Senator.

Senator **Conrad**. Welcome.

Mr. **Remillard**. I'm Dave Remillard, chief executive officer for North Dakota Health Care Review, a physician-sponsored nonprofit organization, which has been designated by the Health Care Financing Administration as a peer review organization for the State of North Dakota. The purpose of the PRO program is to ensure that medical services provided to medicare beneficiaries are medically necessary, are provided in the most appropriate setting, and meet professionally recognized standards of quality.

The most striking and consistently reported problem identified by hospitals and physicians in rural North Dakota is the lack of appropriate services outside of the acute care hospital to which patients can be referred for treatment. There are often gaps in the range of resources available in rural communities. These gaps produce pressures to admit some patients to the hospitals which are not consistent with criteria North Dakota Health Care Review and HCFA have developed for determining medical necessity and appropriate setting of care.

Practicing physicians recognize that the appropriate care of a patient involves consideration of all the patient's needs, physiological as well as social and psychological. Furthermore, practicing physicians face the reality of inadequate community resources and unavailability of alternate facilities on a 24 hour a day basis. In the absence of the alternate facilities, the caring physician must frequently choose hospital admission for the patient, what they need for custodial care, for the very anxious and demanding, or for a patient who needs observations in a controlled environment. Physicians who ignore these needs face loss of patient trust and possible litigation. In these cases, one sees evidence of a forfeit of the Medicare Prospective Payment System to the real world of clinical medicine. Lack of correlation results in considerable antagonism against the Medicare Prospective Payment System on the part of physicians and hospitals.

The 1988 budget reconciliation bill included a requirement that PRO norms take account of, number one, special problems associated with delivery of care in remote rural areas; number two, available service alternatives to inpatient hospitalization; and number three, social factors that affect safety and efficiency of service delivery. These requirements have been delayed by the regulatory process. It appears implementation of these regulations would be beneficial to physicians, hospitals, and a peer review process in North Dakota.

There can be little doubt that a Prospective Payment System raises the potential for patient care compromise. The payment system rewards providers for the most effective use of health care services. While greater efficiency should be encouraged in any industry, and in the short term improve quality, shortcuts in health care outcomes must be monitored and corrected. Over time the PRO program has placed greater emphasis on quality.

North Dakota Health Care Review has uncovered individual problems of poor and compromised care delivered by providers, and through peer interventions have monitored and corrected these deficiencies. The North Dakota Health Care Review does not find evidence to support a general or consistent pattern of quality abuses or early discharge from hospitals. North Dakota hospitals and physicians continue to provide health care services to medicare beneficiaries.

We recognize the serious problem posed by the growing Federal deficit, but the continuing limitations of medicare payments will produce compromises in both accessibility and quality of care. It is difficult, if not impossible, to predict in advance at what level these limitations will adversely affect quality and access. The thresholds of these effects will, of course, vary according to individual circumstances.

We have not addressed any of the payment policies that could be considered to help rural institutions, because they're outside of our purview, yet we suspect that modification in the PRO review activities need to be combined with payment policy revisions.

Senator, we thank you for this opportunity to present our views and recommendations, and I'll be glad to respond to any questions you may have.

Senator CONRAD. Thank you, Dave.

[The prepared statement of Mr. Remillard follows:]

STATEMENT OF
NORTH DAKOTA HEALTH CARE REVIEW, INC.
BEFORE THE
SENATE BUDGET COMMITTEE

FEBRUARY 16, 1989

PRESENTED BY: DAVE REMILLARD
CHIEF EXECUTIVE OFFICER,
NORTH DAKOTA HEALTH CARE REVIEW, INC.

Senator, I am Dave Remillard, Chief Executive Officer for North Dakota Health Care Review, Inc. (NDHCRI), a physician sponsored, non-profit organization which has been designated by the Health Care Financing Administration as the Peer Review Organization (PRO) for the State of North Dakota. On behalf of NDHCRI, I want to thank you for this opportunity to participate in these hearings and to share with you our experience of conducting medical review in North Dakota.

The purpose of the PRO program is to ensure that medical services provided to Medicare beneficiaries are medically necessary, are provided in the most appropriate setting, and meet professionally recognized standards of quality.

With the advent of the Prospective Payment System in 1984, it was perceived by HCFA that the financial incentives of PPS would decrease the average length of stays in acute care hospitals and increase the rate of admissions. There were also concerns that Prospective Payment System with the DRG method of reimbursement would encourage the withholding or limiting of needed services and the early discharge of patients who still required the services of an acute care hospital. Additionally, hospitals were paid according to principal diagnosis (DRG's) which is the primary reason the patient was admitted to the hospital. There was concern there was financial incentives to miscode to maximize DRG reimbursement. It was around these issues that PRO review was directed.

Immediately, both nationally and in North Dakota, the average length of stay dropped approximately 2 days. This was directly attributable to the change from a cost method of reimbursement to a prospective payment method of reimbursement. The number of unnecessary admissions, however, did not increase as anticipated. Of the Medicare admissions reviewed by NDHCRI, less than 2% were found to be inappropriate at the acute level of care. North Dakota statistics are slightly lower than national averages. In reviewing the accuracy of coding of the principal diagnosis, which determines the DRG payment, we found it necessary to change approximately 7% of the cases reviewed. We believe that the DRG changes normally are the result of honest coding errors or improper identification of the principal diagnosis as opposed to "DRG creep" to maximize reimbursement. Actually, approximately half of NDHCRI DRG changes result in higher reimbursement to hospitals.

There can be little doubt that a prospective payment system raises the potential for patient care compromise. The payment system rewards providers for the most efficient use of health care services. While greater efficiency should be encouraged in any industry and in the short term may improve quality, shortcuts in health care outcomes must be monitored and corrected. Over time, the PRO program has placed greater emphasis on quality including the following:

- Providing generic screens as a tool to identify potential quality problems; and
- Requiring each case selected for retrospective review to be reviewed for the appropriateness of the discharge.

NDHCRI review has uncovered individual problems of poor and compromised care delivered by providers and, through peer intervention, have monitored and corrected these deficiencies. NDHCRI does not find evidence to support a general or consistent pattern of quality abuses or early discharge from hospitals. North Dakota hospitals and physicians continue to provide excellent health care services to Medicare beneficiaries.

We recognize the serious problem posed by the growing federal deficit, but the continuing limitation in Medicare payments will produce compromises in both accessibility and quality of care. It is difficult, if not impossible, to predict in advance at what level these limitations will adversely affect access and quality. The threshold of these effects will, of course, vary according to individual circumstances.

The most striking and consistently reported problem identified by hospitals and physicians in North Dakota is the lack of appropriate services outside of the acute care hospital to which patients can be referred for treatment. There are often gaps in the range of resources available in rural communities. These gaps produce pressures to admit some patients to hospitals that are not consistent with the criteria we have developed for determining medical necessity or appropriate level of care.

Practicing physicians recognize that the appropriate care of a patient involves consideration of all of the patient's needs, physiological as well as social and psychologic. Furthermore, practicing physicians face the realities of inadequate community resources and unavailability of alternate facilities on a 24-hour-a-day basis. In the absence of alternate facilities, the caring physician must frequently choose hospital admission for the patient with an acute need for custodial care, for the very anxious or demanding, or for the patient who needs observation in a controlled environment. Physicians who ignore these needs face loss of patient trust and possible litigation.

In these cases, one sees evidence of a poor "fit" of the Medicare Prospective Payment System to the real world of clinical medicine. Lack of correlation results in considerable antagonism against the Medicare Prospective Payment System on the part of physicians. The 1988 Budget Reconciliation Bill included a requirement that PRO norms take account of:

(1) Special problems associated with delivery of care to remote rural areas;

(2) Availability of service alternatives to inpatient hospitalizations; and

(3) Social factors that affect safety and efficacy of service delivery.

These requirements have been delayed by the regulatory process. Implementation would be beneficial to physicians, hospitals and the peer review process in North Dakota.

There continues to be a need for beneficiary education and community outreach programs. Many beneficiaries believe their stay in the hospital is determined by the number of days assigned to a DRG as opposed to the medical necessity for continued stay. Beneficiaries need to be informed of the alternatives if they feel they are being asked to leave the hospital to soon.

We have not addressed any of the payment policies that could be considered to help rural institutions because they are outside of our purview. Yet, we suspect that modifications in PRO review activities need to be combined with payment policy revisions.

Again, we want to thank you for this opportunity to present our views and recommendations. I would be glad to respond to any questions that you or other members of the Committee may have.

Senator **Conrad**. I think we'll proceed with Dr. Podrygula.

I want to welcome Dr. Podrygula, who is a psychologist here in Minot, and someone who has taken a keen interest in involvement in health care issues, not only in a local and state level, but a national level as well. Welcome, Dr. Podrygula.

STATEMENT OF DR. STEPHAN PODRYGULA, PSYCHOLOGIST, MINOT, ND

Dr. **Podrygula**. Thank you, Senator. My name is Dr. Stephen Podrygula. I am a clinical psychologist in Minot, and I am the past president of the North Dakota Psychological Association. In addition to my full-time position at a publicly-funded community mental health center, I have a part-time private practice focusing on behavioral medicine and rehabilitation.

It is a pleasure to appear before you this evening to present a psychological perspective on the crisis in rural health care. In particular, in my written testimony, I had planned on—verbally planned to focus on ways to improve accessibility under services of medicare with an emphasis on the mental health needs of the elderly.

It is my firm belief that the crisis in health care in both urban and rural settings will not be satisfactorily resolved until we design and implement a comprehensive and integrated health care system, primarily responsive to the needs of patients and based on scientific research in regard to the effectiveness and efficiency of services. We must simultaneously address the issues of accessibility and affordability. They are inextricably linked.

I had planned, like I said, to focus on the issue of accessibility, particularly to mental health services for the elderly. In view of the lateness of the hour and in view of the comments previous speakers have made, I guess I would just like to submit my written testimony for the record and just focus on a few smaller issues.

I guess as a psychologist, part of my training is to comment on the process of things of what goes on. And in listening to the other speakers here, I am really depressed. This has been one of the most depressing meetings I have ever attended. I think that's the reality, because——

Senator **Conrad**. I'm sorry, Steve. You ought to sit on the budget committee if you want to be depressed.

Dr. **Podrygula**. I don't have that privilege yet. But, really, this is a very depressing and obviously emotionally-charged issue. I speak as a provider, and I can certainly understand Dr. Ketterling's strong emotions about this. It's a difficult position to be in.

Just some random comments here in terms of what other people have said. First of all, I think that as the population ages, increases in health care costs are inevitable. I don't think there's any way of getting around that. The only issue is how fast will they increase. I'm afraid that Dr. Ketterling may be right, that we're looking at some very difficult choices, rationing, or whatever words we want to call it.

The second point is that listening to people here, I'm really starting to believe that national health insurance of one kind or another may be the only option.

One of the things I am struck with is all the paperwork I have to fill out in my private practice and in the clinic setting and in the hospital. I think that time spent by physicians, psychologists, nurses, stenographers could be used much more productive. I think there's a tremendous amount of wastefulness there.

A third comment I guess is that there need to be stronger incentives for staying healthy. If we have a market-based insurance system, then I think we need to base premiums on risk. If you are overweight, if you smoke, if you have high cholesterol levels, I think there has to be increased payment for that. I don't see how we can avoid that. I think people need to be rewarded for staying healthy, for having healthy behaviors and healthy lifestyles.

Fourth point is I think we need to make maximum use of preventive strategies.

Senator CONRAD. Steve, could I intercede? I just want to indicate to you, I don't smoke, I've got the lowest cholesterol level in the United States Senate. Do I get a rebate?

Dr. PODRYGULA. I would hope you could, because it takes things like that to get people to do those kinds of behaviors. But we may have to look at that if we do look at an insurance system.

A fourth comment I think I would like to make is we really need to make maximum use of preventive strategies. We need to address the issue of lifestyle diseases. And the only part of my written testimony that I will read from will be focusing on that in just a little bit here.

Fifth comment, I think we need to really use public health strategies. I am pleased to see Dr. Wentz here. I think that is the only real way to holding down costs or maybe even controlling the rate of increase or maybe reducing costs.

I guess I would like to offer one small point of light. I can't be like the President and offer a hundred or a thousand points of light. But as a psychologist, I am aware of some research and of some approaches to health care that offer some limited potential, at least, to reduce costs and improve quality of care. Now, since funds for health care are limited and, according to some, even declining, it is critical that we use what money we have more wisely and creatively. Our decisions must be based on efficiency and quality of care. And specifically, we can no longer afford to ignore the data that some approaches to health care are more efficient than others.

And I want to focus for a minute here on a psychological approach. That's called the cost offset phenomena, which is very well established in the scientific literature. This is the finding that the use of medical services decreases when appropriate mental health services are provided. Numerous studies have shown decreases ranging anywhere from 5 to 80 percent in medical service use following mental health treatment. This offset effect has been documented with a wide variety of patients and various health care settings. The studies typically find savings on the order of 60 to 70 percent. We're talking about adding a service being sensitive to a set of needs that people have that will save money.

What is most interesting from our perspective here is that the effect, this cost offset is greatest with the elderly. The cost offset phenomena offers the hope of reducing overall health care costs, not just controlling them. I should also add that this way of controlling costs does not have a negative impact on the quality of care, something which often cannot be said about other cost containment strategies.

Let me give you a simple example of what a behavioral approach might be. There is a variety of studies I am familiar with regarding providing very basic kinds of psychological services to people undergoing surgery. Things like informing them about what the surgery is about, helping them expect—know what to expect in terms of pain, in terms of recovery, teaching them some basic pain management strategies, teaching them some relaxation skills, things like that. Studies I have seen show that 1 hour of that kind of psychological service—which can be delivered by a psychologist, well-trained nurse, a lot of different kinds of providers—can save approximately ten times in terms of what the extra medication cost will be, the extra length of stay. Another way of looking at it is if you provide good quality services like this, you can cut the average length of hospital stay by from about 8.7 days by about 1½ days. I don't know how much the average hospital care a day costs in North Dakota. But if you can spend $100 for a psychologist's time to teach the patients these kinds of strategies and you can gain back a day and a half in patient care, I think that could be a tremendous savings, not to mention the earlier return of the patient to a family situation, to a healthier lifestyle, and getting that patient out of the hospital.

I think it's those kind of approaches we need to look at. We need to look at public health approaches, like encouraging use of seat belts, discourage smoking. The thing with the seat belts really came to mind to me. I was out looking for a new car on Saturday, just looking around. I sat in this one car, and I almost got decapitated by this automatic seat belt. I found that very strange. I always use my seat belt and try to drive carefully. And I thought, why are they putting this bizarre device—it's got to be very expensive, it's got to be very complicated, I don't know how many people it's going to strangle—why do they put these in cars? The reason they put it in cars is people don't like to use their seat belts. We haven't developed good public health strategies to encourage people to use their seat belts. And we really haven't bitten the bullet with air bags. If we had air bags in cars and seat belt laws and other ways of keeping people safer, we wouldn't need these kind of devices, and we also wouldn't have patients in rehabilitation programs with severe head injuries, head injuries from which they're never going to recover, head injuries from which their families are never going to recover, and costs of care from which our society will never recover.

We think we need to be very serious about these kinds of things. In urban settings, I think we need to look at noise and air pollution. We just can't ignore those kinds of public health problems.

I guess to close, I want to make a couple of comments here. In my written testimony, in particular, I have spoken from the point of view of a practitioner who provides health care services to the community and of a person interested in the role of public policy in ensuring quality health care.

I also wanted to compliment Senator Conrad on having this series of hearings in North Dakota and soliciting input from a wide variety of individuals. This is a good way of actualizing the concept of accessibility, making accessibility real.

Attempting to resolve the crisis in rural health care will take cooperation, some planning, sacrifice, leadership, and some innovative approaches. North Dakotans have faced innumerable crises in our hundred years of statehood. Can we resolve this one? I believe that, yes, we can.

In closing, I wanted to thank you for the opportunity to testify before you this evening, and I would be happy to answer any questions you might have. Thank you.

Senator CONRAD. Thank you very much, Dr. Podrygula.

[The prepared statement of Dr. Podrygula follows:]

TESTIMONY OF

Stephan Podrygula, Ph.D.

before the

UNITED STATES SENATE

BUDGET COMMITTEE

Honorable Kent Conrad, Chair

on

Thursday, February 16, 1989

in

Minot, North Dakota

Senator Conrad and Members of the Committee:

My name is Dr. Stephan Podrygula. I am a clinical psychologist in Minot and the Past President of the North Dakota Psychological Association. In addition to my full-time position at a publicly funded community mental health center, I have a part-time private practice, focusing on behavioral medicine and rehabilitation.

It is a pleasure to appear before you this evening, to present a psychological perspective on the crisis in rural health care. In particular, I would like to focus on ways to improve accessibility of services, under Medicare, with an emphasis on the mental health needs of the elderly.

It is my firm belief that the crisis in health care, in both urban and rural settings, will not be satisfactorily resolved, until we design and implement a comprehensive and integrated health care system, primarily responsive to the needs of patients, and based on scientific research in regard to effectiveness and efficiency. We must also simultaneously address the issues of accessibility and affordability; these are inextricably linked.

In my testimony, I would first like to focus on the issue of accessibility, then on the one of cost, and conclude with a discussion of two case studies, representing clinical and administrative issues I have personally had to face.

Accessibility

In terms of increasing the accessibility of services, I see two primary issues: first, increasing the number of providers, and second, using more innovative approaches in delivering health care services.

In the mental health area, a few simple, but important, legislative and regulatory changes could dramatically increase the number of highly trained providers. At the federal level, Senator Jay Rockefeller and Congressman William Coyne have introduced legislation to recognize clinical psychologists as independent providers under Medicare, and directly reimburse them. In passing, I want to note that our state's entire congressional delegation has co-sponsored this legislation, both in the current Congress and the previous one. I wanted to take this opportunity to publicly thank Senator Conrad for his co-sponsorship of S. 100. Adding psychologists to the pool of potential providers would dramatically improve accessibility: this would triple the number of doctoral level mental health professionals in our state, as there are almost twice as many licensed psychologists as there are psychiatrists; these psychologists are also better distributed throughout the state, rather than just being concentrated in the large urban areas in the east. At the state level, some simple changes in the Medicaid rules could do the same; this would also greatly increase the availability of services to the indigent and those without health insurance. One could even expand the pool of providers to include board certified psychiatric social workers and specially trained psychiatric nurses, something which pending legislation in the North Dakota Legislature proposes to do (at least in terms of mandated insurance coverage for outpatient mental health services).

The other approach to increasing the number of providers involves training, both in terms of creating new health services providers and improving the skills of existing ones. The University of North Dakota, for example, recently received a large federal grant to develop a model demonstration program to train professionals to meet the human and health service demands of rural communities. The system of family practice residency training programs, throughout North Dakota, is another example of a creative training approach. It has done a lot to improve the quality of health care in our state, and to train physicians who will be sensitive to the needs of rural residents. In terms of the training of clinical psychologists, the University of North Dakota has had an accredited program for many years. It, and the North Dakota Department of Human Services, have recently developed a coordinated practicum and internship program, to provide more training settings for UND students, and, hopefully, encourage them to stay in the state. Several colleagues of mine and I have been involved in this effort and we are pleased to have had senior level graduate clinical psychology practicum students at the Human Service Center in Minot for the second straight year. Training programs for a variety of health care professionals can significantly improve both quality and accessibility of care.

In addition to increasing the number of providers, use of more innovative delivery systems can improve accessibility of services. For example, there are various ways in which outpatient services, which are cheaper and more easy to get to, can be encouraged. We also need to pay more attention to the notion of a continuum of care, or spectrum of services. We must create alternatives besides simple outpatient services or institutional care, whether it be for "mental" or "physical" health problems. We need to develop more effective community support systems, nutritional programs, recreational activities, etc., for the elderly, to try to maintain them in their homes as long as possible. Unfortunately, such services are often the first to be cut in times of financial adversity. To my way of thinking, this is a "penny wise and pound foolish" attitude. I understand that there are some nursing homes, for instance, in the eastern part of the state that are actively involved in developing community support systems, and even group living arrangements, where the elderly can receive special assistance.

We need to examine and create new roles for hospitals. One model could involve developing a "hub and spoke" system, whereby hospitals in the larger communities of the state could serve as hubs for health care, with the hospitals in smaller, nearby communities serving as the spokes. For example, the larger hospitals could provide administrative and technical support to the smaller institutions, with the latter automatically referring their more complex cases to the larger facilities. Outpatient clinics, in communities too small to support a hospital, could also be integrated into the system, along with health maintenance organizations, and independent providers.

Another option would be for hospitals to diversify and develop nontraditional services. Small rural hospitals already sometimes function as nursing homes, in terms of the "swing beds" that many of them have: the same facility can provide both intensive treatment services and long-term care, depending upon the needs of the patient. Other alternatives would involve hospitals developing activities centers for seniors, nutrition programs for the elderly who live in the community, and even day care facilities for children. Hospitals could also more assertively pursue affiliations with independent physicians, psychologists, and other outpatient providers. In Minot, both hospitals have become very active in educational and preventive health care programs.

It seems that there is always more room for increased cooperation and sharing of services by hospitals. Regulatory bodies, such as the State Health Council, need to see that there is an optimal mix of cooperation (particularly when it comes to expensive equipment or facilities) and healthy competition.

Finally, as unpleasant as it may be, we may need to face the fact that some hospitals just are not economically viable and that their continued existence, at least as traditional hospitals, can no longer be afforded (at least not in terms of the overall health care system in the state). I am very mindful of the impact of the closing of hospitals, schools, etc., on small communities; these can tear at the very fabric of a community's existence. However, with our state's economic problems and changes in population, we have to face reality. Cutbacks should be made in a rational and planned out manner. Communities could be encouraged to give up uneconomical hospitals in return for other considerations, such as a higher priority for economic development projects, and guarantees of continued access to health care services (e.g., through regularly staffed outpatient clinics, or outreach visits by physicians and other health care providers). As painful as it may first seem, we really do need to look at consolidating services, whether it be in terms of colleges and universities, school districts, or hospitals. As a psychologist, a good deal of my work involves helping people face unpleasant realities and learning how to better cope with them; we need to apply these sorts of approaches to communities, and not just individuals.

Cost

In terms of the affordability of health care services, I would like to divide my comments into two main areas: the "cost offset" effect of mental health services, and a variety of other approaches to controlling health care expenses. Since funds for health care are limited, and, according to some, even declining, it is critical that we use what money we have more wisely and creatively. Our decisions must be based on efficiency and quality of care. We can no longer afford to ignore the data that indicate some approaches to health care are much more efficient than others.

I want to focus on the cost offset phenomenon, which is very well established in the scientific literature. This is the finding that the use of medical services decreases when appropriate mental health services are provided. Numerous studies have shown decreases ranging anywhere from 5 to 80 percent in medical service use, following mental health treatment. This offset effect has been documented with a wide variety of patients, in various health care settings. The studies typically find savings on the order of 60 to 70 percent. What is most interesting, for our concerns, is that the effect is greatest with the elderly. The cost offset phenomenon offers the hope of reducing overall health care costs, not just controlling them. I should also add that this way of controlling costs does not have a negative impact on quality of care, something which often cannot be said about other cost containment strategies.

The scientific literature clearly demonstrates the efficacy of psychologically based treatment approaches, not just for traditional psychiatric/psychological disorders. In addition to common psychotherapeutic interventions, behavioral medicine programs utilize a variety of other approaches, including cognitive behavioral therapy, structured self-management activities, biofeedback training, and ways of improving compliance with medical interventions. Behavioral medicine approaches have been very effective for stress related disorders, cardiovascular disease, eating disorders, etc. As many authorities in the field have observed, most of the mortality in the United States comes from diseases which involve behavioral factors, such as smoking, obesity, poor nutrition, etc. By teaching people how to engage in healthier behaviors, psychologists and other mental health professionals, can do a great deal to improve the overall quality of health care.

There are a variety of other methods that can be used to help control health care costs. Increasing competition, through preferred provider organizations (PPOs) and other incentives, can be quite effective. An example of this would be the use of nonphysician providers, who can often deliver very high quality basic or specialized care. From a public policy standpoint, we cannot allow any single profession to monopolize health care. In North Dakota, psychologists have consistently worked with professionals from other disciplines and supported efforts to improve the accessibility of health care services (once adequate assurances have been given that quality of care would be maintained). As a group, we have also strongly supported cost containment approaches, such as utilization review and quality assurance. Personally, I welcome demands for accountability in the health care field.

We also need to develop better alternatives to hospitalization. Reimbursement policies need to encourage outpatient services and preventive efforts. Obviously, we need to assure funding for research programs that will help determine what sorts of approaches are effective and efficient.

Case Studies

I would like to focus on two areas that I have personally been involved in and that reflect some of the key issues I have previously talked about. The first is the matter of assuring quality mental health services to the elderly in our nursing homes. The second involves problems that have arisen, with quality of care, because of Medicare and other regulations, in an inpatient program I am involved with.

The elderly, in nursing homes, have major, and often unrecognized, mental health needs. A recent study by the National Institute of Mental Health, found that 62 percent of the residents had emotional, social, and behavioral disorders. In addition, the study found that over 65 percent of the residents were on psychotropic drugs, but did not have a psychiatric diagnosis; this might indicate an inadequate diagnositic workup, inappropriate treatment, the use of medication to control problem behavior, or a combination of all of these. Other research has shown that the suicide rate of the aged who are in nursing homes is approximately four times that of the elderly who are not in nursing homes. In passing, I should note that this information was provided to me by Dr. Mary Harper, Coordinator of Long Term Care Programs, in the Mental Health Disorders of the Aging Research Branch, of the National Institute of Mental Health.

It was statistics such as these, which led the North Dakota Mental Health Association to organize a coalition of consumer and provider groups to lobby the State Health Council to set rules for minimum mental health services in nursing homes. To date, the Health Council has had three hearings on this subject, but has not yet promulgated any rules. Part of this is because of opposition from the nursing home industry, which, from my point of view, is raising very legitimate issues of funding and availability of mental health service providers. Recently, it seems that the industry has acknowledged the existence of significant psychological/psychiatric problems in nursing home residents, and there are signs of a willingness, on all of the parties involved, to work more closely together to try to address these two issues, and see that appropriate rules are adopted and successfully implemented.

There are several possible sources of trained mental health professionals, who could meet the standards that are being proposed. There appears to be consensus that we must make use of both the public and private sectors. Regarding public services, there is already a model within the North Dakota Department of Human Services, that of the Developmental Disabilities (DD) behavior management system. Under this program, trained, master's level, psychologists and behavior analysts work in each regional human service center (under the supervision of a licensed, doctoral level, psychologist). These individuals go out to nursing homes, assess residents who display problem behaviors, develop specific behavior management plans, and then work with the nursing home staff to implement these plans. This model could be very easily adapted to the nondevelopmental disable elderly. However, it would take additional funding for the human service centers and a change in priorities, at the state level. The superintendent of the North Dakota State Hospital has also indicated that his facility would be very interested in providing outreach services to nursing homes. As for the private sector, services could be available from individual psychologists and psychiatrists and also hospitals (e.g., the director of psychiatric services at a Fargo hospital has expressed interest in having his program provide mental health services to area nursing homes). Hopefully, other hospitals, throughout the state, would be willing to develop a cooperative relationship with nursing homes in their vicinity, to provide mental health services.

In terms of funding, there seems to be a consensus that we need to look at multiple sources, such as Medicare, Medicaid, private insurers, and the nursing homes themselves. The regulatory and legislative changes that I earlier spoke about, in Medicare and Medicaid, would be very important in providing an adequate funding base for these services. I would also expect the development of better reimbursement systems to lead to an increase in the number of providers.

I cite this area because it is a good example of various segments of the health care community working together, in a cooperative manner, to improve the quality of care, by dealing with the issues of accessbility of services and funding. Hopefully, by this time next year, a comprehensive plan will have been developed and implemented. This would be an excellent example of North Dakotans working together, getting things done.

While legislation and regulation can spur improvements, they can also cause problems. I would like to cite some difficulties that my colleagues and I have encountered, in trying to provide adequate rehabilitation services, at a Minot hospital, primarily to an elderly population.

After we discharge an individual from our inpatient physical medicine program, we usually recommend a program of outpatient follow-up (e.g., physical therapy, occupational therapy, speech therapy, psychological services, etc.). Medicare home health care criteria have been problematic for us. As I understand the rules, if the person isn't home bound, they are not eligible for any kind of in-home therapy (but are still eligible for simple care provided by a visiting nurse). Unfortunately, many of our patients are elderly and/or live in very rural areas, so it may be very difficult for them to get into town for the needed services. As a result, they often end up not receiving the follow-up care that they need, because they cannot afford it privately and Medicare will not pay for it. Distance just isn't taken into account.

Another problem that we have faced has to do with the Medicare reimbursement criterion that calls for a reasonable expectation of improvement in the patient's condition, if care is to be paid for. We have to document a significant potential for rehabilitation, if the patient is to qualify for Medicare reimbursement. A problem arises when we look at maintenance care, which simply is not covered. Once a patient's progress has basically ended, we cannot keep them in our program. As I indicated earlier, outpatient follow-up services are often unavailable and/or not funded. If the person regresses, they can be readmitted, or provided outpatient services, to try to restore them to their previous level of functioning. Some patients need significant follow-up care, just to maintain their level of functioning and not regress. On the positive side, Medicaid often will pay for such maintenance services.

Recent funding cutbacks, at both the state and federal levels, have had a significant impact on the spectrum of services available in the community. Last year, for example, the local public health unit discontinued providing many types of home health care. We are now having a problem assisting our discharged patients finding, and paying for, things such as personal care attendant services. Because of this, a lot of the elderly will end up in nursing homes, since the support is just not there to maintain them in their homes. Programs such as "Meals on Wheels" are being cut. I think this is an excellent example of the "penny wise and pound foolish" attitude that I spoke about earlier. We need to do everything possible to maintain the elderly in their homes, for as long as possible.

The final problem that we have encountered has to do with the Medicare regulation that does not allow overnight passes. While I can certainly understand the reluctance of Medicare to pay for an empty hospital bed, while a patient is out on pass, this policy can cause significant problems. In rehabilitation work, our patients are often in the hospital for one, two, three, or even four months at a time. After such a length of stay, it does not make any sense to expect an individual to be able to adjust, in one day, from being in an inpatient setting, to being in his or her home. We do the best we can, for example, we are currently in the process of trying to develop an apartment, of sorts, where family members can come and stay with the patient, learn to take care of their needs, and become accustomed to again being around them. We also encourage patients to go out on pass, so they can maintain contact with their families and the normal environments they will be returning to (such as shopping malls, restaurants, homes of friends, etc.). From a psychological standpoint, it would be very good if we could have the flexibility to send patients home for progressively longer periods of time, toward the end of the rehabilitation process, including overnight. Some day treatment facilities, as part of a broader spectrum of care, could also be very useful. Perhaps Medicare rules could be modified to give our patients more of an opportunity to readjust to their home environment.

Conclusion

In my testimony, I have spoken from the point of view of a practioner, who provides health care services to the community, and of a person interested in the role of public policy in assuring quality health care. I have focused on the twin issues of accessibility and cost, with a particular emphasis on the mental health needs of the elderly. I believe that the issues I have raised, however, are more generally applicable.

I also wanted to compliment Senator Conrad on having this series of hearings in North Dakota, and soliciting input from a wide variety of individuals. This is a very good way of actualizing the concept of accessibility.

Attempting to resolve the crisis in rural health care will take cooperation, sound planning, sacrifice, and leadership. North Dakotans have faced innumerable crises in our 100 years of statehood. Can we resolve this one? I believe that yes we can.

In closing, I want to thank you for the opportunity to testify before you this evening. I would be happy to answer any questions that you might have.

DISTRIBUTION OF PSYCHOLOGISTS AND PSYCHIATRISTS IN NORTH DAKOTA

(As of January, 1989)

Distribution by County

County	Licensed Psychologists	Psychiatrists
Grand Forks	26	2
Cass	18	18
Stutsman	10	13
Burleigh	8	6
Ward	6	3
Stark	5	1
Williams	3	0
Walsh	2	0
Ramsey	2	1
Rolette	1	0
Total	81	44

Distribution by Sex

Sex	Licensed Psychologists		Psychiatrists	
Female				
N	17		3	
%		21.0		6.8
Male				
N	64		41	
%		79.0		93.2

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1. The total number of psychologists licensed in North Dakota was 126; 29 had out-of-state mailing addresses; 16 had not renewed their licenses for 1989; 81 had in-state addresses; 7 of those with out-of-state addresses lived in nearby Minnesota cities and towns, and the majority of these probably worked within North Dakota.
2. Of the 53 counties in the state, 10 (19%) had licensed psychologists and 7 (63%) had psychiatrists; there were 3 counties with psychologists but no psychiatrists.
3. The data regarding psychologists came from the North Dakota State Board of Psychologist Examiners as of January 17, 1989. The data regarding psychiatrists came from the North Dakota Medical Association as of January 12, 1989.

Senator CONRAD. Now, reviewing the schedule for this evening, I note that Dr. Wentz concluded 40 minutes ago. Is that approximately accurate? Well, I think what we should do is bring up Dr. Wentz, ask him to testify. If we could ask Dr. Podrygula, and also Dave Remillard, to remain, then we'd open it up for questions and final comments.

Let me just indicate that Dr. Wentz is the state health officer. He is someone that I have enormous respect for. We turn to him very frequently in my office for advice on a whole range of issues that come before the United States Senate, and his advice has always been not only technically very good, my staff people tell me, but the kinds of judgments that he's passed on have been very helpful. And I want to thank you publicly for that, Dr. Wentz, and also to thank you for coming this evening.

STATEMENT OF DR. ROBERT M. WENTZ, STATE HEALTH OFFICER

Dr. WENTZ. Thank you, Senator Conrad. I really appreciate your comments, and I appreciate the opportunity of providing testimony in this evening's hearing. The hour is late, and I understand that people are tired, and I'll try to be brief in my comments.

I'm not going to follow my written testimony exactly, because a lot of the comments I had to offer, the points have been made. But basically, I do support the concerns of the rural hospital administrators with regard to the inequity in terms of medicare reimbursement for the rural facilities and also the reimbursement inequity for physicians. I think it is a problem and is contributing to the survival problems for our rural hospitals and clinics.

Obviously, there are other factors involved that are threatening our rural hospitals. It's not just the reimbursement system. The rural hospitals are facing population declines in the communities, physicians that are leaving, the problems with closure of maternity services because of the malpractice insurance rates, and so forth. So there are a lot of factors that are involved.

And it is a crisis. I would agree with that. We are involved in licensure of the hospitals in our agency, and medicaid certification, and we are seeing hospitals, some of which have already closed temporarily and then reopened and they are continuing to struggle. We know that there are facilities that are getting very close to either having to close their doors or, frankly, we may at some point have to lift a license from a facility. Some of them are getting so close to the edge of being able to provide even the minimum standard of care, that we're quite concerned about how long we can let them continue to carry a license. So that's another concern that we have.

We agree that—it's been pointed out that our staff has taken a look at the contribution of the costs of care in rural hospitals and the effect that if a large number of those hospitals close, that it really would not result in any significant reduction in health care costs. I would agree with the comments that rural hospitals are not the source of a lot of our problems in terms of health care costs.

The other concern we have is with the decreased access to basic care if those hospitals do close. And, frankly, we're trying to figure out what the appropriate role should be of State government in this issue. Should we start looking at the issues of are there certain of the hospitals where we should pull out all the stops to try to keep them open because of their unique geographic location. Is there an interest from the standpoint of State government in trying to assure that some of those facilities do stay open. Because otherwise we are going to see increased problems with access to care.

Those are the primary comments that I had to make in terms of the issue of medicare reimbursement.

There have been a lot of comments this evening with regard to other parts of the problem, and I realize that the cost of care was the subject at another hearing.

I would go so far this evening as to say that I would join those individuals who feel that ultimately the only solution may be a national health program. And I use the term "program," because I feel that, in my mind, from a public health standpoint, we're looking at more than just a payment or reimbursement issue. One of the things that distinguishes the United States from other developed countries is not just the socialized medicine—if you want to use that term—approach, in terms of reimbursement, but the other unique feature of a national health plan is that it establishes a policy, a national policy in terms of where we're headed, what are our goals in terms of health care. And part of that has to do with this whole issue of primary prevention that Dr. Podrygula made reference to.

And from the public health standpoint, when we look at the statistics for North Dakota in terms of our leading causes of death and disability, it is true that you look at those 12 leading causes of death, the majority of those involve chronic diseases or injuries which involve behavioral risks, and the amount of funding that is available for our department or any other public health agency is minuscule when compared to the amount of dollars we're pouring into curative care. We're working on our health issues from the wrong end. We're putting all of our dollars, an increasing proportion of our dollars into curative care. Very little is going into primary prevention. And until we address that issue, we're going to continue to see an escalation of health care costs, and our band-aid approaches to try to fix our reimbursement system are not going to solve those issues.

So I agree with those who feel we're going to have to make a fairly major overhaul of our health care system to address the problems we're facing. That would conclude my testimony. Thank you, Senator Conrad.

Senator CONRAD. Thank you very much, Dr. Wentz. I wanted to report to you, last year when we were considering the catastrophic care bill before the United States Senate, I sent a description of that plan to the senior citizens who would be affected, those who were medicare eligible in the State, and it outlined with great specificity the services that would come through that bill and outlined with great specificity the cost, and I asked people to return a ballot that was enclosed, and I got some 7,000 of them back. Eighty-five percent of the people urged me to vote in favor of that bill.

Interesting to me were the number of comments that were included, which said things like, "I never thought I would say this, but I'm beginning to think we're going to have to have a plan like the Canadian plan." There were literally thousands of comments like that that came back on these surveys. "I never thought I would say this, but I'm beginning to think we have to consider a national health plan." "I never throught I'd say this." And it was interesting, almost invariably those comments were prefaced by that statement, "I never thought I'd say this." And I was interested by that kind of response. So that fits with some of what you reported here tonight.

I wanted to also make one other comment. Dr. Podrygula related the comment of the President on the thousand points of light. The budget committee chairman, after he examined the budget that has been submitted by President Bush, said, "Well, apparently the thousand points of light came without batteries." Maybe that's relevant.

[The prepared statement of Dr. Wentz follows:]

Testimony for

United States Senate Budget Committee Hearing

"CRISIS IN RURAL HEALTH CARE: Medicare and Rural Hospitals"

Minot, North Dakota
February 16, 1989

Presented by
Robert M. Wentz, M.D., State Health Officer
North Dakota State Department of Health and Consolidated Laboratories

The North Dakota State Department of Health and Consolidated Laboratories is in agreement with the rural hospital administrators in this state who feel that the Medicare reimbursement differential for rural hospitals is creating substantial problems for rural hospitals.

Rural hospitals in North Dakota are facing a number of difficult problems and some of these hospitals are likely facing closure in the near future. In addition to the lack of adequate Medicare reimbursement, our rural hospitals are facing population-base declines, loss of physician staff, closure of maternity units related to the increasing costs of medical malpractice insurance, and increasing competition from the large urban hospitals. In some instances, capabilities of rural hospitals are impaired to the point where we have had to seriously consider termination of licensure for the facility.

While we recognize that we can not expect all of the rural hospitals in North Dakota to survive these combined negative influences, we are concerned with the major access problems to primary and emergency health care which could occur if a substantial number of community hospitals in our state are forced to close in the future. We are attempting to work with the hospital industry and the Center for Rural Health at the University of North Dakota in assisting rural hospitals with planning for diversification of services into areas other than acute care. Hopefully this approach will not only improve the availability of health services for North Dakota residents but would also help insure the continued survival of those rural hospitals having a critical geographic location.

We urge Congress to remove the Medicare reimbursement differential for rural hospitals.

Thank you.

Senator **Conrad**. Let's open it up to comments, suggestions, questions that people might have of Dr. Wentz or Dr. Podrygula or Dave Remillard. Questions or comments. Yes, sir. Again, if you'd identify yourself for the record, that would help our stenographer.

Mr. **Duke**. Thank you, Senator. My name is Scott Duke, and I'm the administrator for the Renville-Bottineau Memorial Hospital in Mohall.

Senator **Conrad**. Welcome. I'm going to be in your city tomorrow.

Mr. **Duke**. I understand that, and if you have time, please stop by our hospital and take a little tour.

I come to the microphone tonight in support of many of the comments made by my constituents and the other providers and representatives that were here.

Our hospital is affiliated with a larger hospital, which is Trinity Medical Center—and that brought me to Mohall last summer—and that has been a key to, as Mr. Hoff commented earlier, a turnaround in our hospital. So I bring a bit of an optimistic perspective, although it is——

Senator **Conrad**. Hurray.

Mr. **Duke** [continuing]. Very cautious, because we live, literally, on the edge of closure month by month. And although at the present time we are doing some substantial remodeling and we have some future plans for offering more services, we are very conscientious of the environment, which is very hostile, at best.

And I strongly support you bringing these hearings into North Dakota and letting the people speak their mind. And I know there are a lot of concerned citizens and sometimes they don't all get their voice heard, and so this gives them an opportunity to do that.

My one comment, which being very young—I'm a 26-year-old administrator, and I believe I'm probably one of the youngest. I'm a local graduate of the Minot State College, and I think that speaks of our higher education system in North Dakota. But more importantly, I think we're talking about a philosophy, a way of life, and in North Dakota, we value that very highly. And it is eroding, and we have got to stop that. And obviously health care is just one of the bare necessities which is needed to have a community and have that way of life.

And in Mohall, obviously I think the support is there, but without those dollars, obviously we can't do it. Eighty-six percent of all of our patients in our hospital are medicare. And I think that percentage is probably going up as the demographics change in our area and you see the population shift. So, clearly, without adequate reimbursement, our hospital will close.

And another critical issue which has been alluded to earlier is professional staff. And we are currently at the same levels as starting nurses get in Minot, and we are still not able to retain some of our nurses that are local because of the type of health care which is out there, and the image.

So very, very optimistic about where we're going and what's happending at the hospital, and I think there's an upbeat attitude, as well as being cautious. But we have learned to live within the system, as restrictive as it is, but we cannot continue with the false promises and things. And I thank you for allowing me to speak.

Senator CONRAD. Thank you very much for your comments. Other questions or comments? Glenn Fornes.

Mr. FORNES. Again, Glenn Fornes.

Senator, if you will remember, at the time the DRGs were invented, there were those of us among the Silver-Haired Assembly, and also talking to people in Dr. Wentz' office, who recommended a Prospective Payment System, but for all payers. Now, the fact that DRG is prospective, however, I think the only, perhaps the only, prospective payment system, had we gone to a complete all payers prospective system, would that have helped any, or would it help today to do this? Wally, Terry, anybody.

Dr. WENTZ. Perhaps I could try to address that. It perhaps could have helped some, because part of the problem that we're struggling with right now, that has been alluded to a little bit this evening, is the cost shifting problem. And we tend to use the analogy of the balloon and how it's getting squeezed, and when it's squeezed in one place, it pops up in another. So at least an all-payers Propsective Payment System might help address that issue. It might help control the cost shifting. But I still don't believe it would solve all of the problems that we're facing in our health care system.

Senator CONRAD. All right. Any other questions or comments? Yes, sir.

Mr. KYES. Jim Kyes, again. Some of the comments very recently brought a thought to my mind that recently I have had. In the last few years, at some time or other, I have had occasion to talk to doctors or representatives, and the comments would be about their prices. "Well, we charge what Blue Cross pays." I have also had a Blue Cross representative tell me, "Well, we pay what the doctors charge." Now, I wonder what kind of a feedback system we get there. Honest to God. Those statements.

Senator CONRAD. Certainly an area of argument there, isn't there? Anybody want to respond to that? You don't want to touch that, do you?

Dr. WENTZ. Get Insurance Commissioner Pomeroy for that.

Senator CONRAD. Yeah, We had one other hand. Yes, ma'am.

Let me just indicate that this will be our last question. We have an obligation to our stenographer here to end on time. She has really performed quite admirably without a break for a 3-hour hearing, and we appreciate it very much, and we will keep our commitment.

Sister CAMMACK. My name is Sister Rita Cammack. I am an RN at St. Joseph's Hospital, so that's from the perspective that I come from.

I have a comment, actually, on a statement you made about 3 hours ago. And you were speaking, I believe, to Dr. Rinn, and you asked him about would something like the severity of illness or severity clause help the present system. Speaking again as an RN, I can say that that would help me give better care to my patients in the current system. If you're looking at a system of DRGs whee you have an average patient that has a specific amount of money for a specific illness, I get the patients now days that not only are elderly, but they have multiple problems where those costs don't correlate with that. So if the interest is in bringing—or approximating the cost of the institution of illness might help that. I don't know if it's going to help the overall problem. And then will that band-aid stick. Probably not very long, because it's getting wet.

Along with that, I think the thing that I have to say is—and I appreciate your comments, Doctor, when you were talking about the emotional care of patients being a priority if you want to decrease illness, sickness, et cetera. We are so oriented towards illness in our present systen, that our orientation towards health is dying, and we've got to change that orientation, I believe, if we're going to be a healthier system, be a healthier people. And that's how I want to care for my patients is on that kind of level. Thank you very much.

Senator CONRAD. Thank you very much.

Let me just indicate that anyone who would like to extend what they have said here tonight or provide additional testimony, we will hold the record open for 2 weeks.

And I want to thank all of you for coming, for participating, and for being a part of establishing the record for the Senate Budget Committee. Thank you very much, and especially thank the witnesses.

[Whereupon, at 9:35 p.m., the committee adjourned.]

American Hospital Association

AHA

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February 14, 1989

The Honorable Kent Conrad
United States Senate
Washington, D.C. 20510

Dear Senator Conrad

I am writing to convey the appreciation of the American Hospital Association for your leadership on health care issues and for your convening the field hearing on Medicare hospital payments scheduled for February 16, 1989, in Minot, North Dakota.

Medicare hospital payments have been the source of budget reductions for the federal government for several years. These cuts are largely responsible for declining hospital operating margins and the deteriorating fiscal "health" of institutions. A growing indigent care burden, rising costs for labor and technology, and the sixth consecutive year of Medicare payment increases below cost caused more than half of the nation's hospitals to lose money caring for Medicare patients. The average hospital operating margin in 1989 for Medicare patients will be -5.5 percent. In 1988, 81 hospitals closed their doors. Many more hospitals are curtailing services, thus further jeopardizing access to care for the community.

These statistics are even more startling for hospitals located in rural areas. In 1988, over half of the hospitals that closed were in rural areas, and the average operating margin projections for rural hospitals in 1989 will be -6.9 percent. No more budgetary savings can be gleaned from Medicare hospital payments without threatening the nation's hospital system and further eroding access to care for many communities, particularly rural communities. The budgetary choices are difficult for our nation's policy makers. But the time has come to protect our communities' access to high quality care and protect Medicare from further reductions for fiscal year 1990.

But our work to preserve access to care and provide for an equitable and adequate reimbursement system does not end with stemming off further budget reductions. The American Hospital Association believes that significant reforms are needed in the Medicare prospective payment system to ensure that the prices set are both adequate and equitable. AHA recommends a series of reforms to achieve these goals.

Adequacy would be achieved through assuring that payments bear a reasonable relationship to the cost of services used by Medicare patients. Prices would be recalculated every four years based on cost, and prices would be updated by the percentage increase in the price of the goods and services hospitals must purchase to provide care.

Equity would be achieved through the establishment of a single "base" rate adjusted for patient characteristics and differences between hospital markets in prevailing resources, prices and variations in use of resources that are beyond the control of hospital management. Current policy for indirect medical education and disproportionate share adjustments should be continued. To improve the sensitivity of the prospective payment system to differences in patient characteristics, the DRG system would be refined, focusing on "problem" DRGs. The inadequate current adjustment for resource price variation would be replaced by a more comprehensive index reflecting variation in the prices paid by hospitals for all types of resources, both labor and non-labor. An exceptions process should be developed to deal with the unique circumstances of individual hospitals that may not fit the general rule. To address the problems of small hospitals experiencing sharp reductions in utilization and operating margins, these hospitals should be allowed to "opt-out" of the current prospective payment system. For these hospitals operating fewer than 50 Medicare certified acute care beds, Medicare reimbursement should be based on traditional cost-based principles.

These are the principal elements of the American Hospital Association's recommended Medicare reforms. The AHA urges your careful consideration of these comments and concerns. We stand ready to be of further assistance and, toward that end, are providing you with a series of publications that provide you with data on our nation's hospitals including rural hospitals.

Sincerely,

Jack W. Owen

Jack W. Owen
Executive Vice President

Attachments:

American Hospital Association Board Approved Position on Medicare Prospective Pricing Reform (January 28, 1989)
AHA Third Annual The State of the Nation's Access to Hospital Services
AHA Hospital Closures 1980-1988 - A Statistical Profile
AHA Environmental Assessment for Rural Hospitals 1988

AMERICAN HOSPITAL ASSOCIATION POSITION ON MEDICARE PROSPECTIVE PRICING REFORM*

Approved by Board of Trustees
January 28, 1989

The American Hospital Association believes that significant reforms are needed in the Medicare prospective pricing system to ensure that the prices set are both adequate and equitable. Adequate and equitable payment is essential to realizing the incentives in the system to improve efficiency while assuring beneficiary access to needed, high quality hospital care.

ADEQUACY REFORMS

For payment to be considered adequate, it must cover the full economic cost of providing needed hospital care to Medicare beneficiaries. Over time, Medicare payments must bear a reasonable relationship to the cost of services used by Medicare patients. To achieve this goal, the prices established under the prospective pricing system should be recalculated every four years using an expanded definition of the cost of caring for Medicare patients. Between these quadrennial recalculations, prices should be updated by the percentage increase in the price of the goods and services hospitals must purchase to provide care. The "hospital market basket " to be used in updating prices should be based on the prices hospitals must pay for the resources they use, particularly labor.

For providers exempt from the prospective pricing system, a more timely means of adjusting payment limits of individual providers for changes in case mix and treatment is needed.

To insulate the Medicare program from pressures to arbitrarily reduce payment levels, Medicare should be exempted and removed from the Gramm-Rudman-Hollings budget deficit reduction measures and removed from the consolidated budget of the United States.

EQUITY REFORMS

Equity is best achieved through the establishment of a single "base" rate which is adjusted for patient characteristics and for differences between hospital markets in prevailing resource prices and variations in use of resources that are beyond the control of hospital management. Movement to a single rate system must be accompanied by a hold harmless provision which protects hospitals from a reduction in payment resulting simply from the movement to a single rate. Individual hospitals, whether urban or rural, would not be protected from any reductions in payment resulting from changes in the DRG system or the updating and expansion of the resource price/use adjustment. The current indirect medical education and disproportionate share adjustments should be continued.

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* This statement updates the American Hospital Association's position on Medicare prospective pricing reform, incorporating actions approved by the AHA Board of Trustees on January 28, 1989. All of pages two, three, and four of this statement represent a summary of the January 28, 1989 Board actions.

DRG Refinement and Severity Adjustment The DRG system is the principal means of adjusting hospital payments for patient characteristics. To improve the sensitivity of the prospective pricing system to differences in patient characteristics, the DRG system should be refined as quickly as possible.

Efforts should focus on the refinement of "problem" DRGs. Initially, an effort should be made to identify modifications in those DRGs which account for more than one percent of Medicare admissions and which show substantial differences in costs between hospitals, which contain individual diagnoses (or groups of related diagnoses) or procedures which differ substantially from the average of other diagnoses or procedures included in the DRG, or which include diagnoses or procedures that have been identified as incorrectly classified by hospitals or physicians.

Rationale The DRG system has been widely criticized for its failure to capture the "severity" of a patient's condition, and considerable resources have been expended in developing "severity measurement systems" to either replace the DRG system or to be used alongside it. The available severity systems offer little improvement over the DRG system in defining groups of patients using similar resources. DRG refinement is consistent with the basic structure of the DRG system and is consistent with the need to continuously improve the payment system to reflect changes in medical practice and to identify truly similar patients. Any improvements that might be realized by the introduction of a severity index or add-on can be realized through the DRG refinement. The continued development and evaluation of these systems, however, may identify important patient characteristics which could be used to improve the DRG system.

Resource Price and Use Adjustments The current adjustment for resource price variation is inadequate, and should be replaced with a more comprehensive index reflecting variation in the prices paid by hospitals for all types of resources, both labor and nonlabor. This index should include, on a selective basis, adjustments for resource use, and must be combined with a flexible exceptions process to identify and make corrections in the treatment of individual hospitals or groups of hospitals when appropriate. While a comprehensive index is being developed, steps should be taken to update the data used to measure differences in wage levels and to add components measuring regional differences in energy/utilities and liability insurance costs.

Rationale An index based on all types of resources would result in adjustment for all variations in resource prices whenever such variations are present, and would allow the validation of inflation as measured by the hospital market basket. Including all types of resources would avoid the need to periodically assess whether various types of resources are traded in local or national markets . Although significant problems with the use of MSAs to define hospital resource markets have been encountered, alternative definitions have proven to be equally unsatisfactory. MSAs offer a viable starting point for the definition of such markets, provided a means of redefining market areas on an exceptions basis is created.

Exceptions Process However refined the adjustments for patient mix and resource price, an exceptions process will be needed to take into consideration the unique circumstances of individual hospitals that cause them not to fit a general rule. All routine adjustments make the assumption that hospital are "average," and will work well for the majority of hospitals. Some hospitals will simply not fit into such a system of "averages." Hospitals should have the option of seeking exceptions through either binding arbitration or through adjudication before a regional appeals boards.

The determination of the boards should be final, subject only to appeal to the courts. All hospitals should be permitted to request exceptions, whether or not financially distressed. The issues subject to appeal should include: inappropriate assignment to a local market, errors in data or in calculations, variation in resource prices, and variation in resource use. Priority could be given to hospitals incurring losses as a result of inequities.

Rationale At the present time, opportunities for appeal or exceptions are extremely limited. By law, most decisions concerning payment under the prospective pricing system cannot be reviewed by the courts. Moreover, because the system is "prospective" a premium needs to be placed on the timely adjudication of exception requests . Under a prospective pricing system, an exceptions process that is not timely is of little or no use. Creating several regional review boards speeds the process by allowing more cases to be heard simultaneously across the country. Limiting further review to direct appeal to the courts also streamlines the process, as does providing hospitals with the option of binding arbitration. Access to judicial review is the best assurance of neutrality. The exceptions process should extend to all hospitals the opportunity to seek a fair price. Restricting appeals to hospitals in financial distress would preclude correction of inequities for many hospitals, including competitive inequities that, over time, may jeopardize the ability of hospitals to compete fairly with one another. At issue is whether payment is fair, not whether payment is simply adequate.

Treatment of Small Rural Hospitals Small rural hospitals have experienced sharp reductions in utilization and operating margins since the implementation of PPS. They also appear to experience substantial fluctuations in both average costs and payments from year to year. To address these concerns, hospitals operating fewer than 50 Medicare certified acute care beds should be offered the option (reviewable every four years) of being paid according to traditional Medicare cost-reimbursement principles . Criteria should be developed for granting the same option to larger hospitals (including urban hospitals) that are the sole source of care for their communities.

Rationale Payment under a prospective pricing system can be unsuitable for many small rural hospitals because they lack the volume needed to reliably predict either revenues or costs. Exempting small hospitals would provide assurances of continued access to hospital services for the communities served, although it would not guarantee a hospital's survival. Development of criteria to provide the same option to larger hospitals (including urban hospitals) that are the sole source of care for their communities would help to ensure that access to needed hospital care is also maintained in selected other communities where the hospital's bed size and/or geographic location do not precisely conform to the small, rural hospital criteria.

Prepared by the
Hospital Data Center

American Hospital Association

AHA

HOSPITAL CLOSURES

1980 - 1988

A Statistical Profile

HOSPITAL DATA CENTER

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DEFINITION OF TERMS

A **hospital closure** is defined as the physical closure or corporate cessation of a hospital facility, or the discontinuation of inpatient medical admissions as of Dec. 31 of each year. Hospital mergers and consolidations are not included. Closure information was acquired by direct report to the American Hospital Association, and through an end-of-year canvass of each state hospital association and licensure agency. Each closure was verified by a representative of the closed hospital whenever possible.

Community hospitals include all nonfederal, short-term, general and other special hospitals whose facilities are open to the public; excluded are hospital units of institutions, psychiatric hospitals, and alcoholism and chemical dependency facilities.

Noncommunity hospitals include federal hospitals, long-term hospitals, hospital units of institutions, psychiatric hospitals, hospitals for tuberculosis and other respiratory diseases, chronic disease hospitals, institutions for the mentally retarded, and alcoholism and chemical-dependency hospitals.

Control refers to the type of organization responsible for establishing policy concerning the overall operation of the hospital. The four major categories are government, nonfederal; nongovernment, not-for-profit; investor-owned (for-profit); and government, federal.

Size refers to the number of beds set up and staffed for use in the hospital as reported to the American Hospital Association. The tables contain breakdowns by size categories: 6 to 24 beds, 25 to 49, 50 to 99, 100 to 199, 200 to 299, 300 to 399, 400 to 499 and 500 or more.

Census regions refer to the nine geographical regions into which the U.S. Department of Commerce, Bureau of the Census, divides the 50 states.

An **urban area** is defined as a metropolitan statistical area (MSA), which is a geographical designation that represents an intergrated social and economic unit with a large population nucleus. The U.S. Office of Management and Budget defines an MSA as a "city or urbanized area of at least 50,000 population with a total metropolitan area of at least 100,000 population." MSAs are defined as entire counties, except in the six New England states where they are defined in terms of cities and towns. In addition to the county containing the main city, an MSA also includes additional counties within a specified commuting distance of the central counties and must meet certain standards regarding metropolitan character, such as population density.

A **rural area** is defined as a nonmetropolitan statistical area with a total population of less than 50,000.

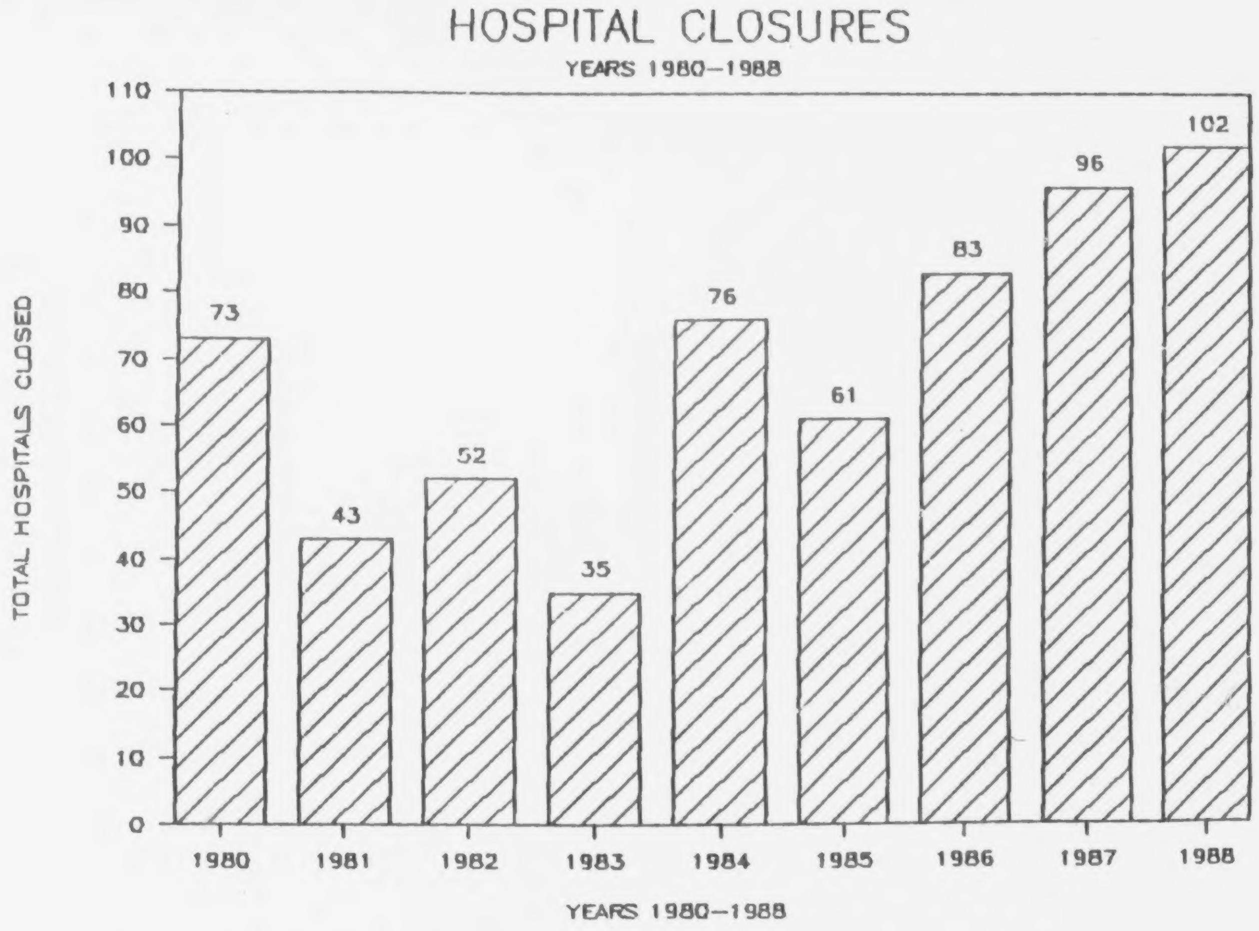
Sources: Hospital Statistics 1988 Edition, AHA Membership Administration records and files, annual surveys, state associations, state licensure agencies and AHA Hospital Data Center files.

CENSUS REGIONS

1	**New England**	Connecticut Maine	Massachusetts New Hampshire	Rhode Island Vermont
2	**Middle Atlantic**	New Jersey	New York	Pennsylvania
3	**South Atlantic**	Delaware District of Columbia Florida	Georgia Maryland North Carolina	South Carolina Virginia West Virginia
4	**East North Central**	Illinois Indiana	Michigan Ohio	Wisconsin
5	**East South Central**	Alabama Kentucky	Mississippi	Tennessee
6	**West North Central**	Iowa Kansas North Dakota	Minnesota Nebraska	Missouri South Dakota
7	**West South Central**	Arkansas Louisiana	Oklahoma	Texas
8	**Mountain**	Arizona Colorado Idaho	Montana Nevada New Mexico	Utah Wyoming
9	**Pacific**	Alaska California	Hawaii Oregon	Washington

HOSPITAL CLOSURES BY YEAR, 1980-1988

Year	Total	Community	Noncommunity
1980	73	45	28
1981	43	27	16
1982	52	23	29
1983	35	25	10
1984	76	45	31
1985	61	49	12
1986	83	71	12
1987	96	79	17
1988	102	81	21
Total	621	445	176


HOSPITAL CLOSURES
YEARS 1980–1988
TOTAL HOSPITALS CLOSED
110
100
90
80
70
60
50
40
30
20
10
0
73
43
52
35
76
61
83
96
102
1980
1981
1982
1983
1984
1985
1986
1987
1988
YEARS 1980–1988

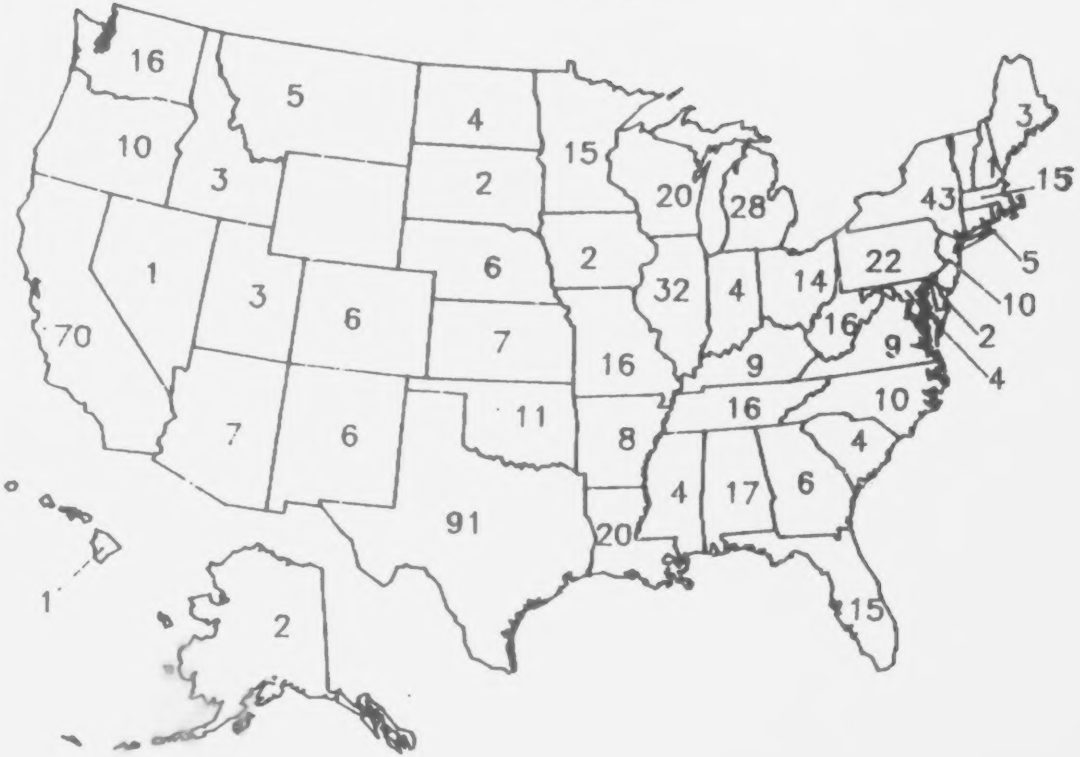
HOSPITAL CLOSURES BY YEAR, 1980-1988

(Urban/Rural, Community/Non-community)

Year	Urban	Urban Community	Urban Noncommunity
1980	51	30	21
1981	30	16	14
1982	29	9	20
1983	25	18	7
1984	49	27	22
1985	37	28	9
1986	44	34	10
1987	54	39	15
1988	56	38	18
Total	375	239	136

Year	Rural	Rural Community	Rural Noncommunity
1980	22	15	7
1981	13	11	2
1982	23	14	9
1983	10	7	3
1984	27	18	9
1985	24	21	3
1986	39	37	2
1987	42	40	2
1988	46	43	3
Total	246	206	40

Hospital Closures
By State
1980-1988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15

HOSPITAL CLOSURES 1980-1988

By State, Alphabetically

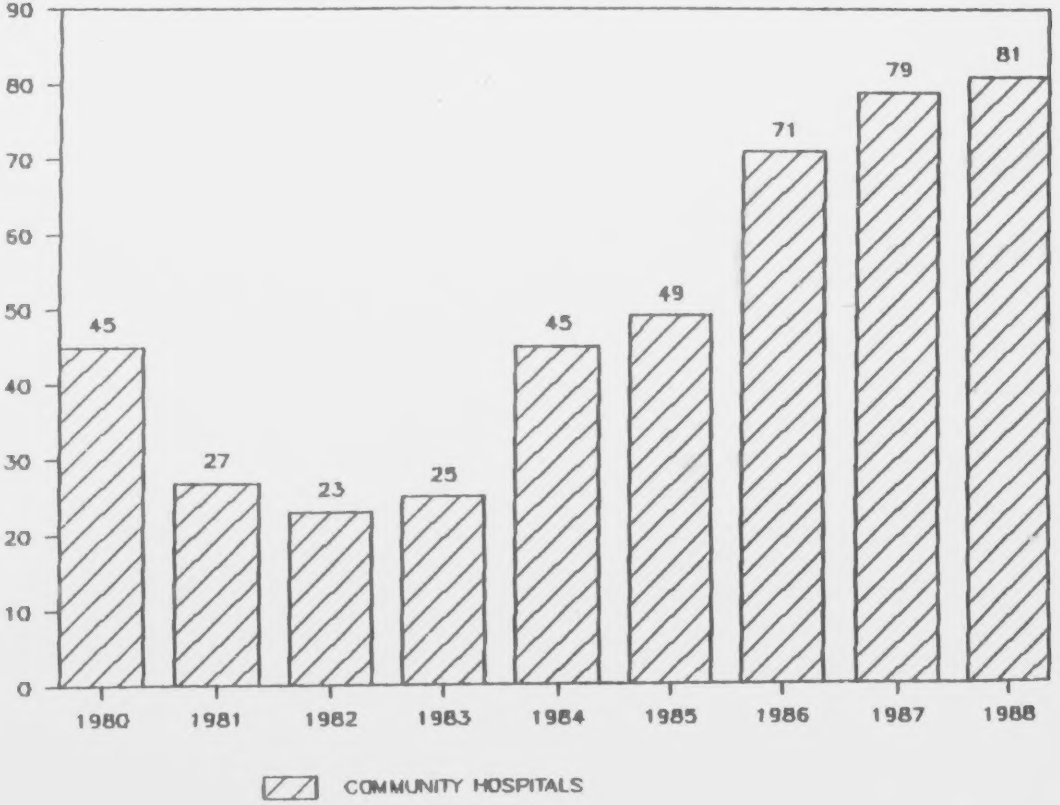
State	Number of Closures
Alabama	17
Alaska	2
Arizona	7
Arkansas	8
California	70
Colorado	6
Connecticut	5
Delaware	2
District of Columbia	0
Florida	15
Georgia	6
Hawaii	1
Idaho	3
Illinois	32
Indiana	4
Iowa	2
Kansas	7
Kentucky	9
Louisiana	20
Maine	3
Maryland	4
Massachusetts	15
Michigan	28
Minnesota	15
Mississippi	4
Missouri	16
Montana	5
Nebraska	6
Nevada	1
New Hampshire	1
New Jersey	10
New Mexico	6
New York	43
North Carolina	10
North Dakota	4
Ohio	14
Oklahoma	11
Oregon	10
Pennsylvania	22
Rhode Island	0
South Carolina	4
South Dakota	2
Tennessee	16
Texas	91
Utah	3
Vermont	0
Virginia	9
Washington	16
West Virginia	16
Wisconsin	20
Wyoming	0
TOTAL	**621**

By State, Ranked

State	Number of Closures
Texas	91
California	70
New York	43
Illinois	32
Michigan	28
Pennsylvania	22
Wisconsin	20
Louisiana	20
Alabama	17
Tennessee	16
Missouri	16
West Virginia	16
Washington	16
Florida	15
Massachusetts	15
Minnesota	15
Ohio	14
Oklahoma	11
New Jersey	10
Oregon	10
North Carolina	10
Virginia	9
Kentucky	9
Arkansas	8
Kansas	7
Arizona	7
Nebraska	6
Georgia	6
Colorado	6
New Mexico	6
Montana	5
Connecticut	5
North Dakota	4
Maryland	4
Mississippi	4
South Carolina	4
Indiana	4
Utah	3
Maine	3
Idaho	3
Alaska	2
Iowa	2
Delaware	2
South Dakota	2
Nevada	1
Hawaii	1
New Hampshire	1
District of Columbia	0
Rhode Island	0
Vermont	0
Wyoming	0
TOTAL	**621**

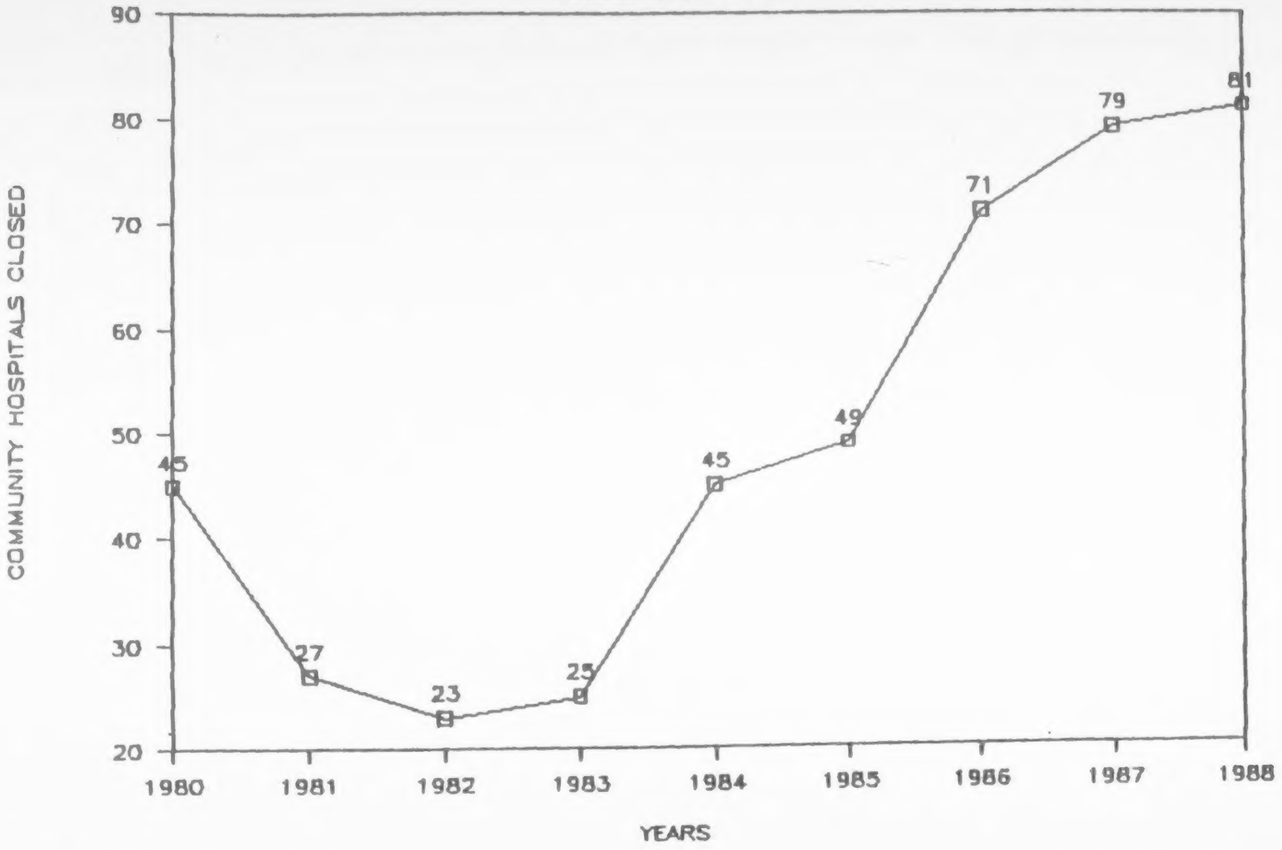
COMMUNITY HOSPITAL CLOSURES

YEARS 1980–1988



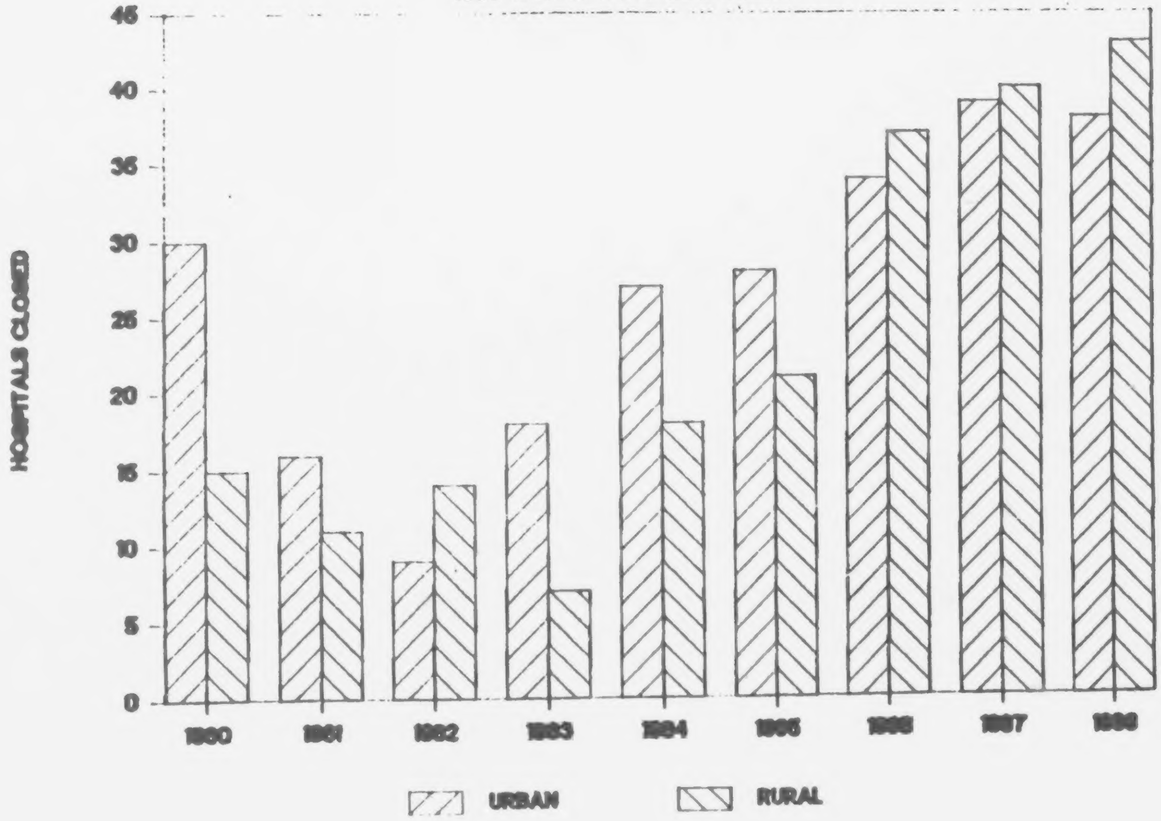
COMMUNITY HOSPITAL CLOSURES

YEARS 1980–1988



COMMUNITY HOSPITAL CLOSURES

1980-1988 URBAN VERSUS RURAL



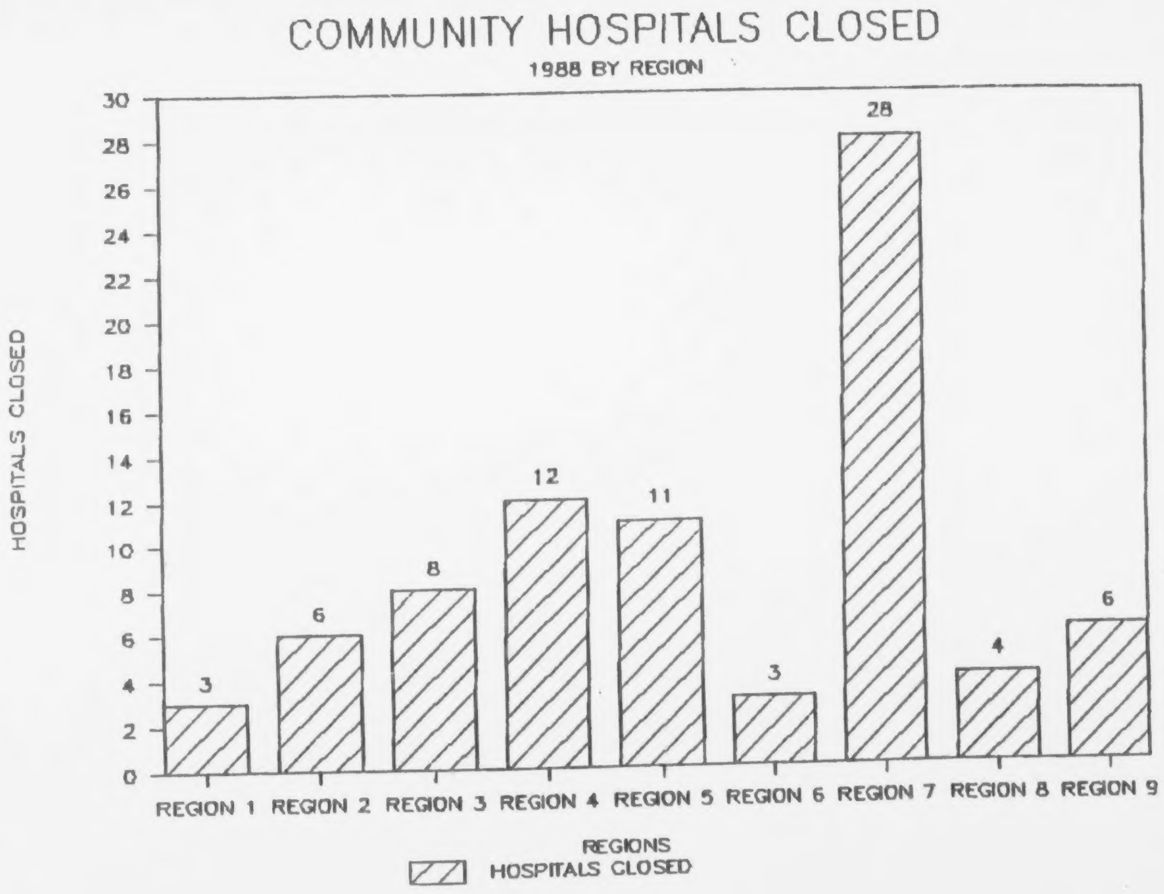
1988 Community Hospital Closures

Region	Number of Hospitals	Beds*
New England	3	140
Mid Atlantic	6	517
South Atlantic	8	299
East North Central	12	1445
East South Central	11	656
West North Central	3	201
West South Central	28	1577
Mountain	4	257
Pacific	6	535
Total	81	5627

Bed Size Codes	Number of Hospitals	Beds
1 = 6-24	13	239
2 = 25-49	28	914
3 = 50-99	20	1425
4 = 100-199	15	1895
5 = 200-299	4	851
6 = 300-399	1	303
Total	81	5627

Control	Number of Hospitals	Beds
Government, Nonfederal		
13 - County	2	164
14 - City	1	99
15 - City/County	1	111
16 - Hospital District	5	183
Nongovernment, Not-for-Profit		
21 - Church-operated	7	1045
23 - Other Not-for-Profit	34	2292
Nongovernment, Investor-Owned		
31 - Individual	3	69
33 - Corporation	28	1664
Total	81	5627

*Staffed beds as reported to the American Hospital Association


COMMUNITY HOSPITALS CLOSED
1988 BY REGION
HOSPITALS CLOSED
30
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REGION 1
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REGION 4
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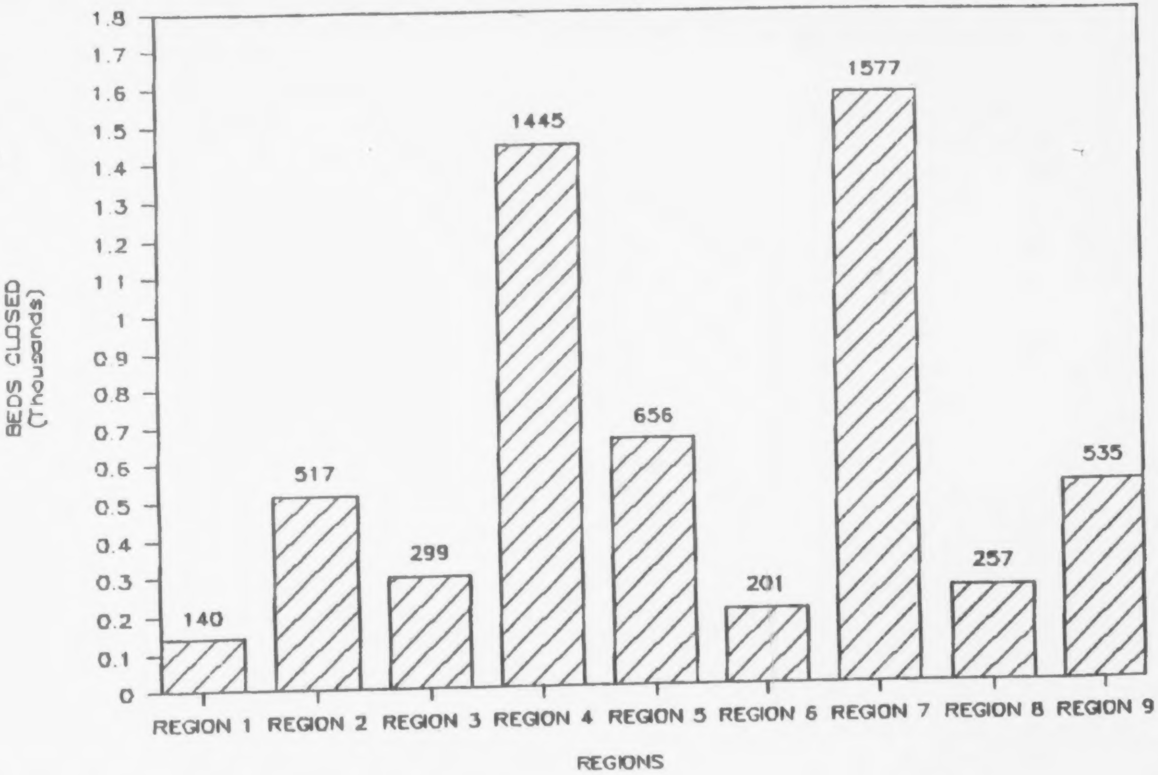
REGIONS
HOSPITALS CLOSED

COMMUNITY HOSPITAL BEDS CLOSED 1988
BY REGION

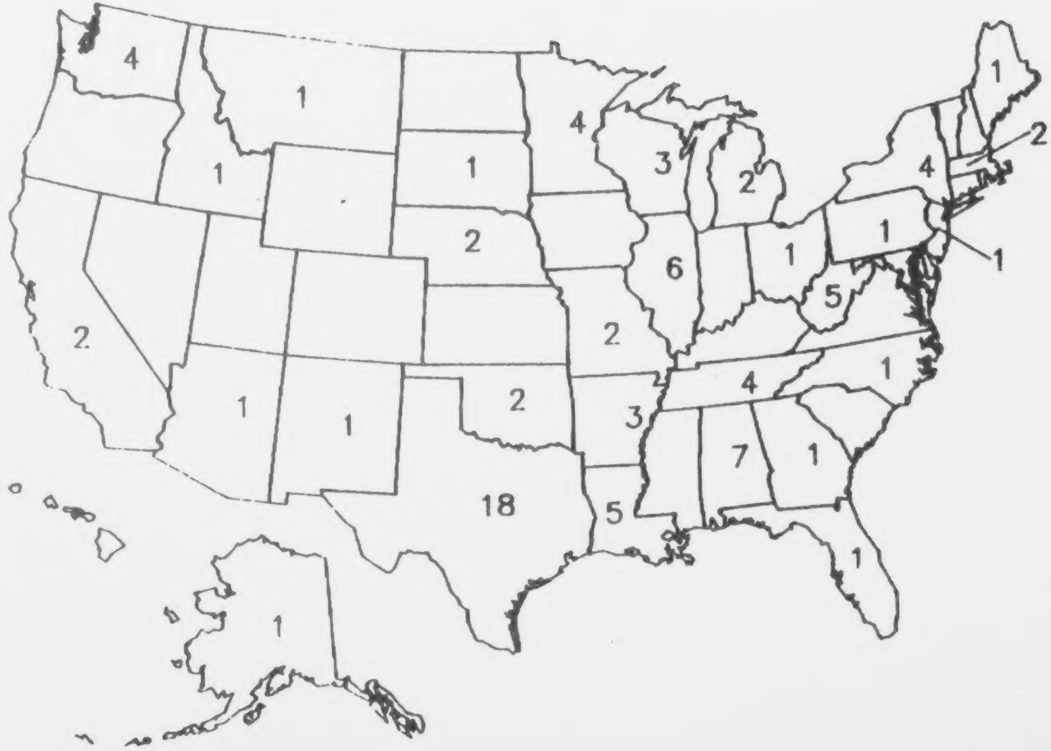


1988 COMMUNITY HOSPITAL CLOSURES BY STATE

State	Number of Hospitals	Beds*
11 - Maine	1	12
14 - Massachusetts	2	128
21 - New York	4	263
22 - New Jersey	1	94
23 - Pennsylvania	1	160
35 - West Virginia	5	138
36 - North Carolina	1	35
38 - Georgia	1	29
39 - Florida	1	97
41 - Ohio	1	66
43 - Illinois	6	777
44 - Michigan	2	96
45 - Wisconsin	3	506
52 - Tennessee	4	183
53 - Alabama	7	473
63 - Missouri	2	180
65 - South Dakota	1	21
71 - Arkansas	3	214
72 - Louisiana	5	166
73 - Oklahoma	2	52
74 - Texas	18	1145
81 - Montana	1	29
82 - Idaho	1	17
85 - New Mexico	1	9
86 - Arizona	1	202
91 - Washington	4	287
93 - California	2	248
Total	81	5627

*Staffed beds as reported to the American Hospital Association

Community Hospital Closure
By State
1988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1988 URBAN COMMUNITY HOSPITAL CLOSURES

Region	Number of Hospitals	Beds*
New England	1	56
Mid Atlantic	4	379
South Atlantic	2	129
East North Central	8	1198
East South Central	5	207
West North Central	2	180
West South Central	10	892
Mountain	2	211
Pacific	4	421
Total	**38**	**3673**

Bed Size Codes	Number of Hospitals	Beds
1 = 6-24	5	81
2 = 25-49	4	128
3 = 50-99	13	920
4 = 100-199	11	1390
5 = 200-299	4	851
6 = 300-399	1	303
Total	**38**	**3673**

Control	Number of Hospitals	Beds
Government, Nonfederal		
15 - City/County	1	111
16 - Hospital District	1	70
Nongovernment, Not-for-Profit		
21 - Church-operated	5	886
23 - Other Not-for-Profit	19	1719
Nongovernment, Investor-Owned		
31 - Individual	2	31
33 - Corporation	10	856
Total	**38**	**3673**

*Staffed beds as reported to the American Hospital Association

1988 URBAN COMMUNITY HOSPITAL CLOSURES BY STATE

State	Number of Hospitals	Beds*
14 - Massachusetts	1	56
21 - New York	2	125
22 - New Jersey	1	94
23 - Pennsylvania	1	160
35 - West Virginia	1	32
39 - Florida	1	97
41 - Ohio	1	66
43 - Illinois	5	747
45 - Wisconsin	2	385
52 - Tennessee	3	119
53 - Alabama	2	88
63 - Missouri	2	180
71 - Arkansas	1	50
74 - Texas	9	842
85 - New Mexico	1	9
86 - Arizona	1	202
91 - Washington	2	173
93 - California	2	248
Total	38	3673

*Staffed beds as reported to the American Hospital Association

1988 RURAL COMMUNITY HOSPITAL CLOSURES

Region	Number of Hospitals	Beds*
New England	2	84
Mid Atlantic	2	138
South Atlantic	6	170
East North Central	4	247
East South Central	6	449
West North Central	1	21
West South Central	18	685
Mountain	2	46
Pacific	2	114
Total	43	1954

Bed Size Codes	Number of Hospitals	Beds
1 = 6-24	8	158
2 = 25-49	24	786
3 = 50-99	7	505
4 = 100-199	4	505
Total	43	1954

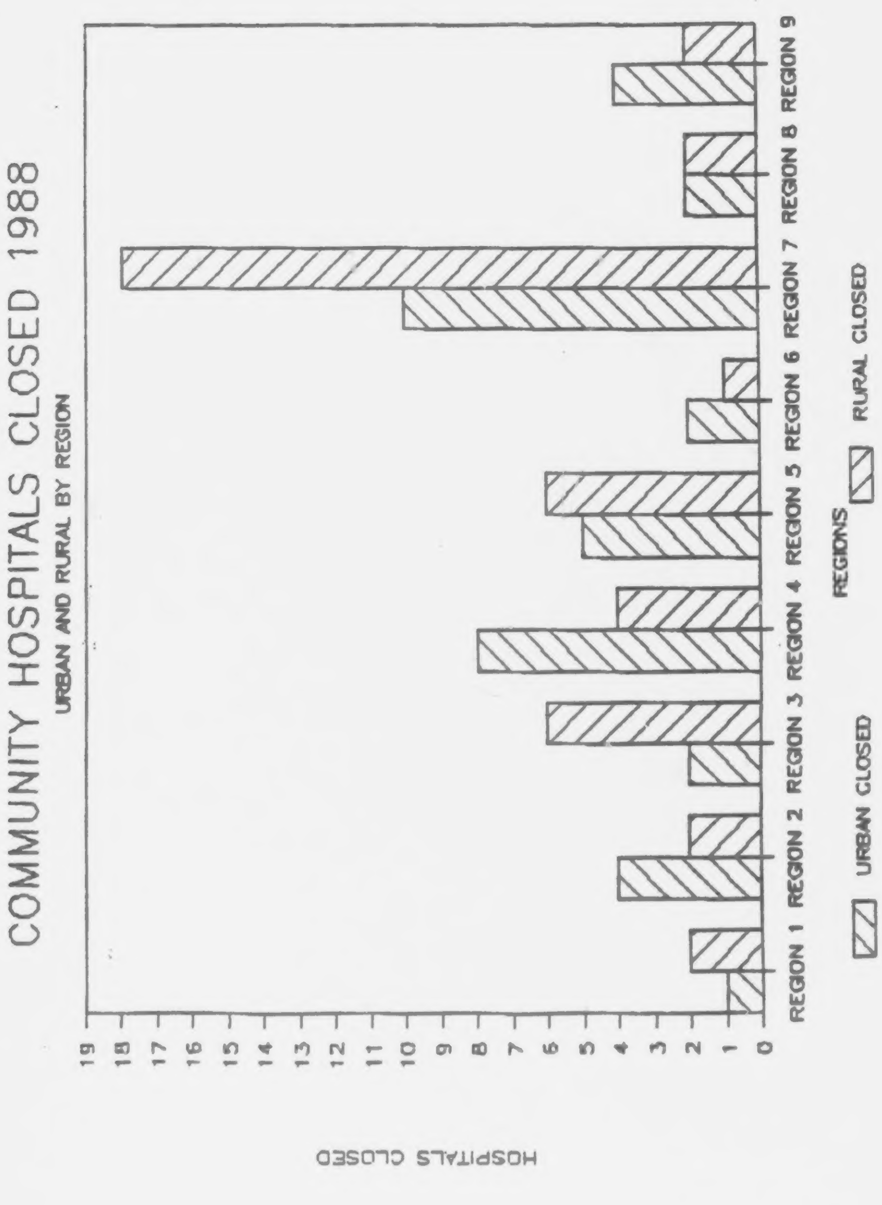
Control	Number of Hospitals	Beds
Government, Nonfederal		
13 - County	2	164
14 - City	1	99
16 - Hospital District	4	113
Nongovernment, Not-for-Profit		
21 - Church-operated	2	159
23 - Other Not-for-Profit	15	573
Nongovernment, Investor-Owned		
31 - Individual	1	38
33 - Corporation	18	808
Total	43	1954

*Staffed beds as reported to the American Hospital Association

1988 RURAL COMMUNITY HOSPITAL CLOSURES BY STATE

State	Number of Hospitals	Beds*
11 - Maine	1	12
14 - Massachusetts	1	72
21 - New York	2	138
35 - West Virginia	4	106
36 - North Carolina	1	35
38 - Georgia	1	29
43 - Illinois	1	30
44 - Michigan	2	96
45 - Wisconsin	1	121
52 - Tennessee	1	64
53 - Alabama	5	385
65 - South Dakota	1	21
71 - Arkansas	2	164
72 - Louisiana	5	166
73 - Oklahoma	2	52
74 - Texas	9	303
81 - Montana	1	29
82 - Idaho	1	17
91 - Washington	2	114
Total	43	1954

*Staffed beds as reported to the American Hospital Association


COMMUNITY HOSPITALS CLOSED 1988
URBAN AND RURAL BY REGION
HOSPITALS CLOSED
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REGION 1
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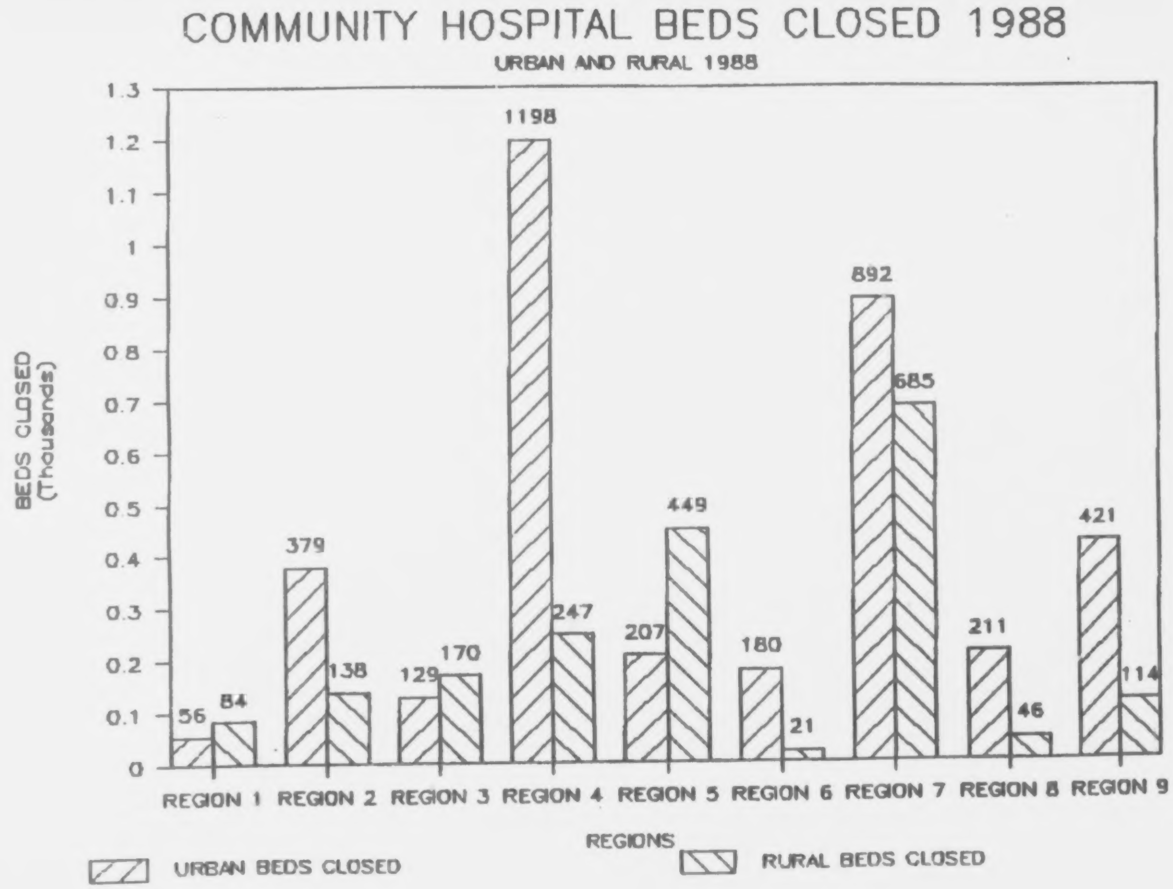
REGIONS
URBAN CLOSED
RURAL CLOSED


COMMUNITY HOSPITAL BEDS CLOSED 1988
URBAN AND RURAL 1988
BEDS CLOSED (Thousands)
1.3
1.2
1.1
1
0.9
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0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
56
84
379
138
129
170
1198
247
207
449
180
21
892
685
211
46
421
114
REGION 1
REGION 2
REGION 3
REGION 4
REGION 5
REGION 6
REGION 7
REGION 8
REGION 9
REGIONS
URBAN BEDS CLOSED
RURAL BEDS CLOSED

1988 NONCOMMUNITY HOSPITAL CLOSURES

Region	Number of Hospitals	Beds*
New England	2	1000
Mid Atlantic	3	527
South Atlantic	1	11
East North Central	4	1444
West North Central	3	758
West South Central	4	2738
Mountain	3	132
Pacific	1	104
Total	**21**	**6714**

Bed Size Codes	Number of Hospitals	Beds
1 = 6-24	4	58
2 = 25-49	2	72
3 = 50-99	4	272
4 = 100-199	2	206
5 = 200-299	1	275
6 = 300-399	1	324
7 = 400-499	2	953
8 = Over 500	5	4554
Total	**21**	**6714**

Control	Number of Hospitals	Beds
Government, Nonfederal		
12 - State	11	5176
13 - County	1	275
Nongovernment, Not-for-Profit		
21 - Church-operated	1	324
23 - Other Not-for-Profit	1	491
Nongovernment, Investor-Owned		
33 - Corporation	7	448
Total	**21**	**6714**

*Staffed beds as reported to the American Hospital Association

1988 NONCOMMUNITY HOSPITAL CLOSURES BY STATE

State	Number of Hospitals	Beds*
14 - Massachusetts	2	1000
22 - New Jersey	2	514
23 - Pennsylvania	1	13
37 - South Carolina	1	11
42 - Indiana	1	650
44 - Michigan	2	519
45 - Wisconsin	1	275
63 - Missouri	2	656
67 - Kansas	1	102
72 - Louisiana	1	1652
74 - Texas	3	1086
84 - Colorado	1	11
85 - New Mexico	1	85
87 - Utah	1	36
93 - California	1	104
Total	21	6714

*Staffed beds as reported to the American Hospital Association

Jamestown
Hospital

419 5th Street N.E.
Jamestown, North Dakota
58401-3360
252-1050

February 10, 1989

The Honorable Kent Conrad
708 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator:

I recently received a letter addressed to my predecessor, Peggy Jukkala, who was formerly the Director of Jamestown Hospital Home Health. As the new Director, I wish to contribute some written testimony to the offical record regarding providing quality health care to rural North Dakota.

Our agency was recently issued a denial of services for fourteen visits made to a 72 year old male, who had injured the index and middle finger of his right hand in a farm accident. This gentleman's closest emergency medical facility is 30 mile one direction through isolated rural North Dakota. The Dr. ordered daily dressing changes to prevent the probable infection of these wounds. Because of the pain and disability of severe injury to the right hand, the gentleman was unable to drive for daily dressing changes. So, Home Health changed his dressing fourteen days in succession until the wound was healed. Medicare denied these visits stating that the man was not homebound. We believe our nurse acted ethically and responsibly in facilitating these daily dressing changes; thus, saving taxpayers a considerably larger bill had he lost his two fingers and needed subsequent hospitalization.

Because we made these fourteen visits, we have been penalized by Medicare. Our agency, for the first time in ten years, has lost its Presumptive Status. I see this not as a financial loss to our agency but rather a loss to the Medicare recipients in this area. Our nurses, who evaluate potential patients, are likely to be more stringent in accepting clients that Medicare may tell us are unacceptible by their criteria. Those patients will likely remain in hospitals longer or be admitted to hospitals sooner since they have not received Home Health Care.

We understand that Medicare is trying to reduce hospitalization costs by sending people home earlier from emergency and acute care facilities.

This of course, is only cost effective if these patients do not need re-hospitalization. The cost of seven visits through Home Health hardly equals the cost of seven days of hospitalization.

Thank-you for your concern for our agency and for rural health in North Dakota. We appreciate having the opportunity to have input into your committee hearings.

Sincerely,

Angela Seitz

Angela Seitz, RN
Director of Home Health
Jamestown Hospital

cjtn
cc: Gorman King/Legal Assistant

NORTH DAKOTA HOSPITAL [redacted] **ASSOCIATION**
AFFILIATED WITH AMERICAN HOSPITAL ASSOCIATION
Representing Member Hospitals and Long-Term Care Facilities

MEDICARE ISSUE PAPER
prepared for
SENATOR KENT CONRAD, NORTH DAKOTA

Issue

Medicare Prospective Pricing (PPS), now in its sixth year, is widely credited with reining in Part A outlays and shoring-up the Hospital Insurance Trust Fund. However, PPS prices do not reflect hospitals' financial requirements....the resources consumed in delivering the care. Payments are not only inadequate, but have been inequitably distributed.

PPS payment methodology must be improved, and additional funding is needed to ensure adequate payments for all types of hospitals.

Status

Since the inception of PPS, the annual update factor set by Congress has been the focus of hospital efforts to ensure payment adequacy. Annual PPS price increases equaling the rate of increase in the hospital marketbasket of goods and services have been sought, while the industry and HHS work to identify better measures of illness severity, labor expense and other resources consumed.

Annual updates, however, have always fallen substantially below the rate of marketbasket increase. During FYs 1984-89, annual updates totaled 14.9 percent, but the hospital marketbasket increased 28 percent! In addition, the Reagan Administration's final budget for FY 1990 proposes a PPS update 1.5 percent below marketbasket.

Reimbursement for capital costs have also been impacted. Under current law, Medicare will reimburse hospitals only 85 percent of capital-related costs in FY 1989 and the FY 1990 budget proposes a 75 percent payment level.

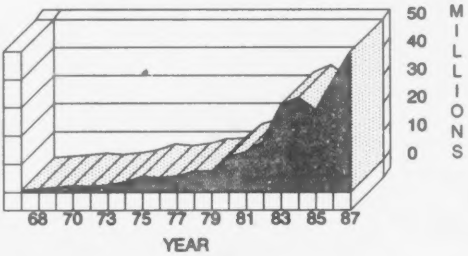
Six years of below-marketbasket PPS updates have taken their toll on hospitals' fiscal health, with margins declining or disappearing! Both ProPac and HCFA estimate that Medicare hospital operating margins for FY 1988 will be between zero and 2 percent, with nearly half the hospitals in the nation suffering losses caring for Medicare patients.

Impact on North Dakota Hospitals and the Patients They Serve

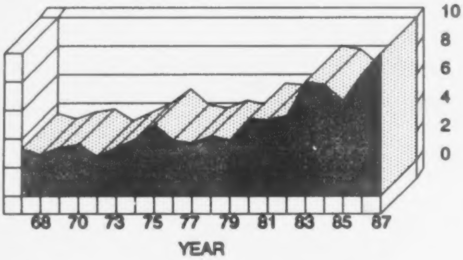
In North Dakota, 51 percent of our hospitals reflected net losses from patient revenues in 1987 and for the first nine months of 1983, 62 percent reflected costs in excess of their patient revenues.

A major contributor to the losses is the shortfall in Medicare payments. As the graph to the right vividly portrays, Medicare discounts resulted in a $50 million revenue shortfall for our hospitals in 1987. For the last seven year's alone (1980-87), the discounts nearly tripled (increased 294%).

MEDICARE SHORTFALLS IN NORTH DAKOTA



% OF TOTAL REVENUE LOST TO MEDICARE BY NORTH DAKOTA HOSPITALS



Stated differently, Medicare discounts stated as a percent of total patient revenue has risen from 5% in 1980 to 10% in 1987, as illustrated on the graph to the left.

In terms of impact on the patients we serve, please consider the following:

If the cost of Medicare discounts in 1987 were spread equally across all patients, it would equate to $472 per hospital stay, or $83 of revenue for every man, woman and child in North Dakota.

Solutions

We have shared with you resolutions gathered by our member hospitals, which petition the U.S. Congress to protect Medicare so hospitals can continue to provide high-quality care, not only for Medicare beneficiaries but for all patients.

Overall, we believe there should be a single base price for urban and rural hospitals, adjusted for severity of illness and resource prices, which would be more equitable than a blanket urban/rural differential.

Attached to this testimony are comments from the hospital associations in South Dakota, Nebraska and Kansas, which mirror our remarks. Additionally, I have included testimony from the American Hospital Association, which presents a national perspective.

Thank you for your consideration.

Arnold R. Thomas,
President

Mercy Hospital
570 Chautauqua Boulevard
Valley City, North Dakota 58072 • (701) 845-0440

February 6, 1989

Sen. Kent Conrad
U.S. Senate
Washington, D.C. 20510

Dear Senator Conrad:

The problems being experienced at this time by rural hospitals are compounding very rapidly. The inadequate reimbursement from Medicare will cause several more rural facilities in America to close in the near future unless changes are made in the way rural hospitals are paid for the care of Medicare patients.

At Mercy Hospital of Valley City, we find that 70% of our inpatient days are Medicare days. That compares to about 40% Medicare inpatient days at area urban hospitals. In addition, we receive up to 40% less reimbursement for the care of Medicare patients than our neighbors in the nearby urban hospitals. These facts create serious problems for our hospital today and in the future.

We find ourselves struggling to compete for competent healthcare personnel, especially nurses and physicians. In the past few years we have lost three physicians (one to retirement and two to urban locations) and several nurses. Clearly it is becoming more and more difficult to retain services and equipment to keep physicians in the rural areas simply because we cannot afford to pay for it - a direct effect of the Prospective Payment System (PPS) and the lack of appropriate Medicare funding. We have seen several of our best nurses leave for urban areas simply because we could not compete with salaries and benefits. It is difficult to see urban competitors spend thousands of dollars on expensive marketing programs when we are often unable to even cover our costs to provide needed rural healthcare services. Healthcare in rural America is in serious trouble.

I am enclosing a study done by our facility a few months ago which compares reimbursement to Fargo hospitals with that of our hospital in Valley City for our most frequent DRG discharges. When we calculate our number of cases for this one year period and the number of discharges for each DRG listed, we find that hospitals in Fargo would have received over $300,000 more in Medicare payment for the same number of corresponding Medicare cases. It's clear that we are at a distinct disadvantage to retain personnel, physicians and market share.

Sen. Kent Conrad
Page two
February 6, 1989

It is necessary for Congress to act now in order to salvage rural healthcare in North Dakota and nationwide. We cannot continue to be paid inadequate dollars to care for Medicare patients and keep appropriate levels of quality service in our rural hospitals. We need your help and we need it now. Support for full market basket increases in Medicare payments is necessary or soon many of us won't be around to talk about it anymore.

Sincerely,

Raymond M. Weisgarber
President/CEO

RMW:rml

Enclosure

cc: Chip Thomas, ND Hospital Association

Mercy Hospital
570 Chautauqua Boulevard
Valley City, North Dakota 58072 • (701) 845-0440

Top 10 DRG Payment Comparison
For Mercy Hospital Discharges from 6/01/87 through 5/31/88

DRG	Payment/DRG Mercy-VC	Fargo #1	Fargo #2	Fargo #3
Heart Failure & Shock	2,443.01	3,495.20	3,309.14	3,189.16
Specific Cerebrovasc. no TIA	2,970.47	4,249.84	4,023.60	3,877.72
Simple Pneumonia & Pleurisy	3,073.96	4,397.89	4,163.78	4,012.82
Angina Pectoris	1,598.64	2,287.16	2,165.41	2,086.90
Esophagitis, Gastroent. & Misc.	1,726.50	2,470.10	2,338.60	2,253.82
Circ. Disord. with AMI C.V. Comp.	4,101.63	5,868.19	5,555.80	5,354.37
Nutrit. Metabolic Disorders	2,212.86	3,165.92	2,997.39	2,888.72
Bronchitis & Asthma	2,343.11	3,352.27	3,173.82	3,058.75
G.I. Hemorrhage	2,360.80	3,377.57	3,197.78	3,081.84
Medical Back Problems	1,599.83	2,288.87	2,167.03	2,088.46
Otitis Media & Uri	1,724.83	2,467.70	2,336.34	2,251.63

Dickey County Memorial Hospital
241 Main Street ● Box 220
ELLENDALE, NORTH DAKOTA 58436
(701) 349-3611

3-9-89

Senator Conrad:

As you recall the testimony I presented in Minot last month contained a look forward to 1991, i.e. hospital closed. We are extremely thankful that yesterday's bus accident (see enclosed) was not more serious! But what would be the outcome in 1991 if the accident had happened then and been more serious???

Even though the two week period has elapsed to include this in the testimony, maybe it could be attached in some way?

Gordon Smith

Gordy

CC: Senator Burdick
Representative Dorgan

Presentation Health System . . . Caring for You Since 1901

siness Face
Cindy Huff at
Gas-n-Goodies 13A

O&A: Outguess

PLAYOFFS: Wolves lose in Montana 15A

TOURNAMENT: Roncalli, Mobridge and Sisseton in 'A' 15A

103rd Year
No. 278

Aberdeen
American News

25 cents
March 9, 1989

Student injuries not serious in N.D. bus crash

Driver apparently passed out

By **RUSS KEEN**
American News Writer

ELLENDALE, N.D. — Sixteen Ellendale students, ages 7 to 16, emerged without serious injury early Wednesday after their school bus struck a highway approach, flew 40 feet and landed upright in a ditch.

Preliminary findings indicate that driver Gordon Kusler, 44, passed out, said Richard Geiss of the North Dakota Highway Patrol.

Dr. Brian Bonte of Ellendale said, "It appears as if he had some fainting spell, or something that caused him to become inattentive."

Passenger Jason Rall, 15, said he suddenly looked up and noticed the bus was heading down the wrong side of the road. "I was yelling at him (Kusler) and couldn't figure out why he wasn't listening."

Rall said the bus went off the road, ripped out a stop sign at the end of a side road, flew through the air and landed on the other side of the side road.

"Everybody was screaming," Rall said.

JASON RALL

The accident occurred six miles west of Ellendale near Pheasant Lake on N.D. Highway 11 at 8:20 a.m., Trooper Geiss said. Kusler was traveling east. He had made all stops for students on his route and was heading back to school when the accident occurred, Geiss said.

Kusler, who sustained head injuries, was transported

(See BUS, Page 3A)

SCHOOL BUS
ELLENDALE
E 8050
CARDINALS

American News photo by Dick Carlson

North Dakota State Trooper Richard Geiss estimated this 21-passenger bus sustained from $800 to $1,000 in damages after it went off a road west of Ellendale, N.D., early Wednesday. Some of the 16 school children aboard sustained injuries ranging from minor to moderate.

Bus: 14 of 16 students treated for injuries

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by ambulance to Memorial Hospital in Ellendale. He was transferred Wednesday to St. Luke's Hospital in Fargo, Bonte said.

Students were transferred by another school bus and stopping motorists to the hospital and Community Health Center, the town's clinic. Hospital administrator Gordon Smith said 14 of the 16 students were treated.

Four of the 14 sustained moderate injuries requiring surgery to repair lacerations, Bonte said. Plans late Wednesday were to keep one student in the hospital overnight for observation, Bonte said. The student was expected to be released today.

Trooper Geiss said 13-year-old Christy Rall was among the moderately injured. She suffered a cut lip and lost four teeth. Her mother, Phyllis Rall, said Christy was home resting after receiving 15 stitches on the outside of her lower lip and 12 stitches on the inside.

Five of Phyllis Rall's' eight children were on the bus. The school office contacted her, as well as the other parents, shortly after the accident. "I was just awfully scared at first, that's all," Phyllis said.

"It's very scary," said Kirk Hansen, Ellendale superintendent of schools. "You have concern not only for those in the accident but the rest of the student body."

Kusler, who lives in Ellendale, has been a regular bus driver for the city's schools for three years. He was a substitute before that, Hansen said. Wednesday's bus accident was the first for the Ellendale school system, he said.

Fears stirred by the incident were tempered by gratitude. "We are real thankful it wasn't any worse than it was," said Wilma Mock. Her granddaughter, 7-year-old Jami Mock, was among the passengers.

Passengers were Amber Brokaw, 7, and Ryan Brokaw, 10, children of Kevin and Jackie Brokaw; Brad Brokaw, 12, Lori Brokaw, 9, and Kelly Brokaw, 6, children of Kim and Cheryl Brokaw; Ann Kronberg, 6, and Christy Kronberg, 8, children of Keith and Kay Kronberg;

Jami Mock, 11, daughter of Don and MaryAnn Mock; Christy Rall, 13, Jason Rall, 15, Roschelle Rall, 12, Mark Rall, 10, and Bethany Rall, 9, children of Melvin and Phyllis Rall; Pamela Wall, 9, and John Wall, 7, children of Darell and Marilyn Wall; and Mike Wagner, 16, son of Jerry and Bette Wagner. All are from Forbes, N.D.